Virginia Department of Medical Assistance Services

Compiled Public Comment Submission Delivery System Reform Incentive Program (DSRIP)

Comment Period 09/11/15 – 10/19/15

Acknowledgements

The Department of Medical Assistance Services would like to thank our community stakeholders and partners who submitted comments on the Delivery System Reform Incentive Program (DSRIP) Concept Paper. We appreciate your input and find many responses valuable as we continue to work towards a comprehensive waiver application. All comments will be taken it into consideration as we move forward.

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Advocate: The Arc of Virginia

Comments on DSRIP Concept Paper

October 19, 2015

Dear Sirs,

This letter is submitted in response to a request from the Virginia Department of Medical Assistance Services (DMAS) for public feedback on a concept paper outlining broad strategies for inclusion in a Delivery System Reform Incentive Payment (DSRIP) waiver/demonstration request.

The paper identifies four basic strategies for reforming the delivery of health services and social supports for Medicaid beneficiaries with chronic disabilities and illnesses: (a) developing integrated service delivery strategies; (b) creating a data platform that promotes service integration and usability; (c) building community capacity; and (d) redesigning DMAS payment systems. Illustrations of the potential benefits of cross-system planning, financing and service delivery are discussed in the paper, with particular emphasis on the integration of health and behavioral health services, treating substance use disorders and delivering long-term services and supports to low-income elders and adults with physical disabilities. Despite the major system change initiatives currently underway within the Commonwealth, however, the concept paper ignores the potential contributions the proposed DSRIP waiver/demonstration program might make toward improving the efficacy and cost-effectiveness of home and community-based services for individuals with intellectual and developmental disabilities.

The state Department of Behavioral Health and Developmental Services (DBHDS), in cooperation with DMAS, is currently in the process of redesigning the state's I/DD waiver programs. The redesign initiative involves a variety of inter-related steps aimed at promoting affordable, integrated day and residential services. These steps include: (a) offering a broader, more flexible array of community supports; (b) bringing payment incentives in line with the goal of community integration; and (c) facilitating the movement of participants from more to less restrictive service settings by co-managing a three-tiered network of waiver programs.

The state's existing community I/DD service system relies heavily on congregate residential and daytime service models.

- In 2012, Virginia had the lowest ratio in the nation of service recipients living with a family member while receiving specialized I/DD services. In addition, less than one percent of the 6,297 individuals residing in group settings were living in settings serving one to three individuals.[1]
- Only 16 percent of individuals receiving employment supports through the Commonwealth's ID waiver program were enrolled in individual supported employment programs, with the balance enrolled in group employment (48%) or sheltered workshop (35%) programs.[2]

[1] Larson, Sheryl, et. al., ***In-Home and Residential Long-Term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and Trends Through 2012***, National Residential Information System Project, Research and Training Center on Community Living, Institute on Community Integration/UCEDD, College of Education and Human Development, University of Minnesota, 2014, Tables 1.3 and 1.5, p. 41 and p. 43.

[2] Virginia Department of Aging and Rehabilitative Services, "Review of Employment Support Services," September 2015 (Discussion Draft), p. 5.

Moreover, access to integrated community housing and daytime support programs has not improved significantly in recent years according the most recent report of the Independent Reviewer in the settlement agreement with the U.S. Department of Justice.[3]

A redesigned set of I/DD waiver programs can establish a framework for broad-scale systemic changes, but the actual transition to a service system that delivers on the promise of integrated living and programming options will be a much slower, more difficult process.

The key to developing such a system is to alter the perceptions of system stakeholders and build local capacity to support individuals in integrated living and day programming settings.

In order to reduce the system's current reliance on congregate residential and day service models and expand access to integrated, individualized community supports, the Commonwealth will have to assist current community agencies to transition from traditional residential and day provider agencies to community support agencies. Among the steps DBHDS might take to assist HCBS waiver providers to transition to community support agencies are:

- *Provide training and technical assistance to willing community agencies on the "nuts and bolts" of converting to a community support model*. Some of this support can be provided by "role model" agencies within the Commonwealth that already operate under a community supports model. Other types of assistance should be made available through a newly created, state-subsidized entity specially equipped to guide existing agencies through the conversion process.

- *Develop mechanisms to assist community agencies in reducing the debt burden associated with obsolete properties through subsidized sales and/or loan forgiveness programs*.

- *Promote cross-system collaboration in transitioning young people with significant physical, behavioral, developmental and sensory disabilities from secondary school to meaningful, productive lives in the community*. Effective, cross-system school-to-work transition services is a key to reducing the current waiting list for I/DD services and placing the next generation of I/DD waiver participants on a pathway to productive, meaningful lives in communities of their choice.

- *Create a community infrastructure that supports enhanced individualization and service integration*. Some of these elements are already in place or being developed in response to settlement agreement requirements (e.g., the REACH crisis intervention system; regional support teams; regional quality improvement forums, etc.). Others will need to be added, with all of the elements melded together in a coherent, overall strategy for promoting more opportunities for individualization and integration.

- *Furnish bridge funding to assist community agencies transition from providers of congregate day and residential services to providers of individual supports designed to maximize community involvement and participation.*

[3] Report of the Independent Reviewer on Compliance with the Settlement Agreement in United States v. Commonwealth of Virginia, June 5, 2015.

- *Establish demonstration programs to pilot new approaches to organizing and delivering community supports and transitioning youth from secondary school to work, especially in areas of the state where limited service and support options currently exist;* and

- *Expand efforts to promote the acceptance of a community support model among existing provider agency, self-advocates and family members, Community Services Boards and especially among case managers and service facilitators.*

These efforts should be augmented by attempts to recruit qualified, out-of-state support agencies to open operations in Virginia, especially in areas of the state with too few providers of supported living, shared living, supported employment, integrated day services and other individualized support programs.

The Arc of Virginia believes that the proposed DSRIP initiative offers the Commonwealth an opportunity to build an I/DD community support system dedicated and equipped to integrate children and adults into the mainstream of community life. The general strategies laid out in DMAS's concept paper are precisely the types of initiatives required to build such a system. In particular:

- Collaborative partnership must be forged at the local level to identify and systematically remove barriers to converting existing community I/DD providers to community support agencies and effectively transitioning youth from secondary schools to productive, integrated community lives. These partnerships should include, at a minimum, school districts, health plans, disability advocates, and vocational rehabilitation, supported employment and daytime service and treatment providers. The adoption of an Employment First policy and the creation of an interagency Employment Leadership Summit have created a policy framework conducive to such local partnerships. But, given the highly decentralized nature of decision-making within the elementary and secondary education system and the community I/DD system, effective, sustained problem solving at the local level is critical. Unfortunately, the infrastructure to undergird such robust local partnerships – and, importantly, the funds necessary to create and maintain this infrastructure -- is currently unavailable.

- An integrated, cross-system data platform is essential to converting existing community I/DD provider agencies to community support agencies and to establishing an effective school-to-work transition program. There are significant variations in the classification and terminology used by education, vocational rehabilitation, social services and adult I/DD agencies. These differences impede the development of a common data platform. Such a platform would link specialty health, behavioral health, rehabilitation, social service and long-term service providers with health care coordinators, Community Services Board case managers and vocational rehabilitation counselors, thus supporting cross-system planning, treatment and financing initiatives.

- Health, behavioral health and long-term services agencies must develop the capacity to furnish the integrated supports necessary to allow individuals with significant disabilities to take their place as participating, productive members of society. Integrated housing options will have to be greatly expanded and additional community support agencies will need to be formed (or recruited from out-of-state) before Virginia's I/DD service system is able to offer integrated, person-centered supports to all Medicaid-eligible individuals with I/DD. Behavioral health, substance use and traumatic brain injury providers face many of the same capacity-building challenges. The DSRIP initiative would help to spearhead efforts to create the additional and re-tooled community capacity that will be necessary to support effective integration of services and smooth school-to-work transitions. The steps taken in states such as Washington, Oregon and

Rhode Island illuminate the pathway Virginia must take as well as offer examples of training and technical assistance strategies that might be employed.

- If Virginians with lifelong disabilities are to grow and prosper in local communities across the state, the funding strategies of local school boards, vocational rehabilitation agencies, social service agencies and long-term service providers must be synchronized. Rather than focusing narrowly on achieving individual system goals (high school graduation; job placement and retention; a stable living and day service environment; and an optimal health status), these human service systems must focus on the whole person, with the aim of assuring that she or he has the supports necessary to live a full productive life in the community. When funding initiatives are built around this umbrella goal, it becomes possible to design collaborative funding strategies that optimize the resources and expertise of all existing human service systems.

More than 10,000 children and adults are currently on waiting lists for specialized I/DD services, and the list keeps growing longer with each passing month. Any realistic plan to reverse this trend must include the modernization of existing I/DD service delivery systems and cross-system strategies to ensure that young adults with I/DD and other chronic disabilities gain prompt access to a coordinated, individualized array of employment, health, housing and long-term supports upon graduation from secondary school. To allow the skills these young people have gained during their school years to deteriorate following graduation is not only a tragic waste of education dollars and human potential but a certain pathway toward much larger expenditures on these individuals down the road. For this reason, ***The Arc of Virginia urges DMAS to include a robust I/DD system change initiative as part of its forthcoming DSRIP waiver proposal***.

Inquiries and requests for elaborations on the contents of this letter should be directed to Rebecca King, The Arc of Virginia's Public Policy Director, at rking@thearcofva.org or by phone at: 804/649-8481.

Sincerely,

Rebecca King

Advocate: Brain Injury Association of Virginia

Thank you for the opportunity to provide comments on DMAS intent to pursue an 1115 innovation waiver to further transform Virginia's Medicaid program through the Delivery Systems Reform Incentive Payment program. Although stakeholder comments are due before the conclusion of the Department's planned focus groups to share more information regarding its plans for submission, BIAV does have some initial thoughts and concerns to share.

1. One of the stated outcomes of this effort will be "an investment in integrated care and community infrastructure for the most vulnerable population, and ensuring the most medically complex enrollees with significant behavioral physical, sensory and developmental disabilities can live safely and thrive in the community." Although this program will serve the current Medicaid population, and that includes many, many persons with brain injury, the lack of access to the long term supports and services available to other populations that allow them to live in the community are inaccessible to most persons with brain injury; we are very concerned that the lack of a Home and Community Based Services brain injury waiver will leave this population vulnerable to a further erosion of limited supports. More than 1,000 Virginians with brain injury are currently in Virginia nursing facilities, which is a nearly 400% increase over 4 years, primarily because there is no brain injury waiver. There are thousands of people with brain injury who will require nursing facility placement when their current primary caregiver is no longer able to fulfill that role. What then? Continue the institutional bias and house them in nursing facilities when their average age is decades younger than most of the other residents? DMAS is already paying huge sums of money to send people with neurobehavioral challenges resulting from brain injury out of state; the individuals have been removed from nursing facilities, or for whom a placement simply cannot be found, because nursing facilities are ill-equipped or simply do not want to provide care to them. A brain injury waiver must be put in place before these Medicaid delivery system transitions are finalized, in order to maximize the services and supports that are critical to a population whose care can be costly, not only in the acute phase, but over their lifespan, if that care is provided in institutions.

2. One of the proposed focus areas of the application is workforce capacity. Persons with brain injury frequently face difficulty accessing services with providers who have any training at all in brain injury, resulting in inappropriate, ineffective, and inadequate treatment…if they get any treatment at all. They have been denied services, including crisis intervention, because they have a brain injury; they have been jailed, sent out of state, relegated to homelessness, and died because of it. At a minimum, any workforce capacity plan must include utilizing current community based specialized brain injury service providers who are already providing critical safety net services. These providers have the necessary expertise and can be valuable partners; they should be included in decisions regarding transition payments and other initiatives, because it is a system that can benefit from efforts to stabilize their ability to provide and grow desperately needed services and supports for this population.

3. Moving Medicaid to a managed care program will likely mean, particularly for those with no home and community based waiver already in place, a shift to an emphasis on the management of medical care…not what someone with brain injury needs 2-3 years after the incident that caused the injury. While brain injury is disease causative and disease accelerative, simply treating only the medical aspects of the injury will not be enough. In the Community Partners Focus Group, I heard someone say "Housing is

healthcare." I very much agree with that statement, and research shows it to be true. Additionally, I would suggest that stable employment, dependable transportation, and circles of support that operate from a person centered philosophy are just as important to long term health as good medical care. Good management of any brain injury survivor will require access to a full continuum of medical and community based supports and services.

4. Building on that idea, I lack confidence that case management provided by managed care organizations will be "conflict-free." The conflict is inherent and unavoidable if the MCO providers are offered financial incentives and are expected to minimize costs; the likelihood that this will truly benefit individuals with extensive care needs is low. I've worked in hospitals and was forced many, many times to watch patients be discharged before they should have been because the insurance company, represented by the case manager, decided it was time. The average length of stay for rehabilitation after brain injury has dropped nearly 8% annually from 2004-2009, and patients are begin discharged quicker and sicker. Insurance provider policies privatize gain and socialize loss, relegating many individuals to a life of disability and dependency. Consideration of how to provide rehabilitation of adequate scope, duration or intensity on the front end could improve outcomes and "bend the cost curve" in a positive direction and away from institutional care if it is done during the infrastructure work design.

I've attended focus groups meetings, sat in on webinars, had conversations with other providers and advocates, read the DMAS concept paper and Kaiser briefs on how DSRIP initiatives look in other states; still, I have found it to be a terribly complex concept to completely wrap my brain around, but I do know the idea of Medicaid moving to capitated managed care concerns me. I saw what it meant in the 1990's and 2000's to the rehabilitation of persons with brain injury when private insurers embraced the model, and I am not convinced insult will not be added to injury for some very vulnerable people when the Medicaid system in reformed in Virginia.

I understand the directive that DMAS is under by the General Assembly to reduce Medicaid costs; I understand the economic and demographics concerns behind it. But I also understand how brain injury has been marginalized, how we have fought for fairness and parity as regards services and supports, and how our participation in important conversations regarding transformation of the waiver and mental health system in Virginia has been limited. We are very grateful to have been included in these discussions and communications; we hope to be part of future conversations and have opportunities to share our ideas and concerns in plans that will have a significant impact on those we care for and about.

Thank you-

Anne McDonnell

Executive Director

Advocate: Children's Health Investment Partnership (CHIP) of Roanoke Valley

To: Cindi Jones, Director, Department of Medical Assistance Services

From: Robin Haldiman, CEO CHIP of Roanoke Valley

RE: DSRIP Public Comment

October 16, 2015

Child Health Investment Partnership (CHIP of Roanoke Valley) is pleased to provide comment on the Commonwealth of Virginia's concept paper "Accelerating Delivery System Transformation in Virginia's Medicaid Program."

We are pleased to see these changes taking place and understand the potential they have in truly transforming care for many of our most vulnerable Virginians.

3.1 Transformation Step #1: Integrate Service Delivery

3.1.1 Team-Based, Integrated Behavioral Health and Primary Care

If the Commonwealth is looking to actually fully integrate service delivery, it must include oral health along with behavioral health and primary care. Integration of oral health into the service delivery system is imperative if Virginia is seeking to avoid unnecessary or preventable hospital utilization. Just as it is important to have behavioral health become a natural extension of primary care, it is equally important to have oral health viewed as a natural extension of primary care. As Medicaid changes over time and oral health is covered for adults, the state would be well positioned to have all aspects of a patient's care incorporated. Within the home visiting program run by CHIP in Roanoke, Va., we view the holistic health as a three legged stool with primary care, oral health and behavioral health. All children enrolled are receiving care coordination for those three physical health outcomes and their parents and all adults should have access to the same.

3.1.4 Addressing Super-UtilizerMany super-utilizers of emergency departments are individuals seeking relief for dental issues. Within our organization we often see drug abuse issues start with individuals seeking relief from tooth pain. A component of the protocols designed with DSRIP funding should include appropriate education of ED staff and providers regarding oral health issues and a referral mechanism to reduce the reliance on the ED for dental issues. VIPs could choose to implement components of the ED diversion model developed by the oral health and primary care integration workgroup convened as part of the Commonwealth's SIM work.

3.2 **Build a Data Platform for Integration and Usability**

3.2.1 Data System Development within VIPs

I applaud the forward thinking that providers be reimbursed for outcomes and would provide the capacity for data analytics. To that end, dental records need to be part of any platform that is built if there is to be fully integrated care.

Again, I appreciate the opportunity to comment on the DSRIP portion of the waiver application and wish your group much success in this important endeavor.

Best,

Robin R. Haldiman
CEO, CHIP of Roanoke Valley

Advocate: George Mason University (GMU)

October 19, 2015
The following comments are submitted to the Virginia Department of Medical Assistance Services (DMAS) pertaining to the DSRIP concept paper "Accelerating Delivery System Transformation in Virginia's Medicaid Program".

The authors and points of contact include:
Terry Wolters CEO NotifiUs 703.403.3133 terry@notifius.com
Kamaljeet K. Sanghera, PhD Assistant Professor, Applied Information Technology. The Volgenau School of Information Technology and Engineering 703.993.1547 ksangher@gmu.edu

Purpose of submission:
Both NotifiUs, LLC and George Mason University are interested in improving healthcare across the Commonwealth, particularly as related to Virginia's Medicaid beneficiaries. This submission is to convey areas of expertise related to the DSRIP, and to gather more information about its requirements and expectations to prepare a final submission for consideration and before approval.

Public Comment and questions on DSRIP
Areas addressed 3.2 Transformation Step #2: Build a Data Platform for Integration and Usability/ 3.2.1 Data System Development within VIPs. 3.1.1 Team-based, Integrated Health and Primary Care/3.1.3 Care Transitions and Diversions from Intuitional Care / 3.1.4 Addressing Super-Utilizers

The proposed model also addresses 3.1.c models of care transitions and diversions from hospitals and institutional care, and 3.1.d d. The approach to avoiding unnecessary or preventable hospital utilization.

Related Background and Suggested approach:

Three professors in George Mason's Department of Health Administration and Policy, Farrokh Alemi, Phan Giang, and Janusz Wojtusiak, recently co-authored three research studies in *The Gerontologist*, the journal of The Gerontological Society of America, that examine data from Veterans Affairs (VA) nursing homes and use predictive modeling to help inform long-term health care decisions. According to the Congressional Budget Office, nearly half of the 8.6 million veterans in the Veterans Health Administration are older than 65, and the fastest growing group is older than 85.

"Benchmarks have not been available to guide clinical care and inform long-term health care decisions," said Alemi. "The data we have available, in this case for patients in VA nursing homes, could be used to optimize health care planning and delivery and personalize care for patients to improve their quality of life."

One study analyzed Activities of Daily Living (ADLs) for nearly 300,000 residents in VA nursing homes to provide benchmarks for the likelihood, time until, and sequence of functional decline and recovery. Using data from the Resident Assessment Instrument Minimum Data Set, which is a standardized, federally mandated process for clinical assessment that is used in Medicare- and Medicaid-certified nursing homes, the authors analyzed data from 16 domains related to ADLs. The analysis demonstrated that 57 percent of nursing home residents followed four different paths of ADL impairments; the most

common order was loss of independence in bathing, grooming, walking, dressing, toileting, bowel continence, urinary continence, transferring, and feeding.

"Understanding the sequence of ADL impairments allows patients, families, and clinicians to set priorities and care plan," Alemi said.

In another study, Alemi, Wojtusiak, and colleagues used predictive modeling to determine methods of anticipating a change in ADLs for VA nursing home patients after they had been hospitalized. Electronic Health Record data for more than nearly 5,600 VA Community Living Center residents was analyzed to establish patterns of recovery and loss of ADL functions. The models the authors developed were able to accurately predict ADLs for 14 days after hospitalization, and although accuracy declined from 14 days to one year post-hospitalization, the models were still able to predict a high number of ADLs.

"This study demonstrates that predictive modeling can be used to identify patients who may be at risk of experiencing a temporary or permanent decline in ADL functions and to identify patients who will improve after hospitalization. Using this information, health care professionals can tailor care plans to address individual patient needs," Wojtusiak said. "Predictive modeling and big data analysis means that we no longer need to talk about an 'average' patient. Instead, we can build accurate individualized models that are tailored to individual patients."

The third study compared hospitalization rates for veterans who were in shared homes as part of the VA Medical Foster Home (MFH) program to those who were in VA nursing homes. The VA MFH program allows patients to reside in a community-based living arrangement as opposed to a nursing home. MFH residents live with a community caregiver who can also address the patient's specific care needs. Access to big data allowed the authors to compare hospitalization rates for MFH patients to those of VA nursing home patients for 14 common conditions, including falls, bacterial infections, and adverse medication effects. Using a matched case control study to account for differences in the data, the authors determined that MFH patients did not have increased hospitalization rates for common medical conditions compared to VA nursing home patients.

"The results of our analysis suggest that 'shared homes' and home-based health care is a safe alternative to nursing home care and does not negatively impact the quality of care or the patient's quality of life," Alemi said. "Our access to big data allowed us to make these comparisons since smaller data sets would not have such exact matches on age, gender, and co-morbidities, which we used in our study."

A similar modeling process for Commonwealth Medicaid participants improves transitions and diversions from hospitals and institutional care and better defines patient needs to help providers avoid unnecessary or preventable hospital utilization. Additionally, the practices and service delivery definitions determined through this process define needed and optimal mobile care teams for Medicaid patients.

Questions:

-What existing data sources are available from the DMAS related to Commonwealth patients enrolled in Medicaid?

- Are Medicaid member costs, number of hospital visits and facility admission reasons available through these sources?

- What current methods and practices are standardized for Medicaid patients related to medication adherence and follow up appointment reminders? Is data available for Commonwealth Medicaid patients on current adherence success levels?

Area Addressed: 3.2.2 Providers Link to a Statewide Care Management System 3.2.3 Statewide Stet of Minimum Data Standards

Related Background and Suggested Approach (GMU):

Electronic symptom checklists can be used to help improve patient-clinician communication.

In 2015, approximately 1.65 million new adult cancer cases are expected to be diagnosed, and an estimated 10,380 new cases are expected in children 14 years old and younger, according to the American Cancer Society. Studies have shown that the adverse effects of treatment experienced by oncology and hematology patients are under-reported in medical records.

The Therapy-Related Symptom Checklist for Adults (TRSC) and the TRSC for Children (TRSC-C) are used to encourage cancer patients to report treatment-related symptoms to their physician. A group of researchers, including Department of Health Administration and Policy Affiliate Faculty Arthur R. Williams and HAP Professor Farrokh Alemi, are taking that one step further and pilot testing the idea of using computers for emotional support and for gathering a patient's symptom information.

To do that, they are examining e-health applications of the TRSC and TRSC-C. Their study, published in BioMedical Engineering Online, discusses the system design and efforts to create an electronic system for the TRSC and TRSC-C that is able to demonstrate empathy, while obtaining a complete list of symptoms from the patient.

"These checklists can be used to help guide patient-clinician conversations so the discussion is more focused and can specifically address treatment concerns and symptom management," Williams said. "Using an electronic system enables patients to have more frequent contact and communication with their clinician."

The pilot test is evaluating an electronic system that combines telephone-voice communications with computer algorithms to allow patients to report symptoms and respond to the TRSC or TRSC-C using a common language. The electronic system's design is focused on the computer's recognition of symptoms, the ability to modify interactions with patients based on the patient's responses over time, and how the computer can use active listening skills to address the patient's concern. These empathetic computer systems are able to demonstrate an understanding of the patient's responses and essentially create a conversation between the computer and the patient.

This program as a patient facing collection of patient information and "emotions" when added to an existing patient EHR serves as a Statewide Care Management System on a central basis and enables integrated clinical, behavioral, and social data.

Questions:

- For the initial trial period how many Medicaid patients are addressable to participate in the development of a comprehensive symptom checklist as part of a new Statewide Care Management System?
- What process will DMAS follow to approve the final elements of the Statewide Care Management System?

Areas addressed: 3.3 Transformation Step #3: / 3.3.3 Telehealth

Related Background and Suggested approach:

NotifiUs, LLC is a small technology company owned by two veterans focused on providing mobile messaging services for applications such as medication and appointment adherence. Expertise includes telecommunications, network integration through "session control" protocols and social media.

Many new technologies are commercially available to expand monitoring of at-home patients, and to aid with safety, such as fall detection and provide more complete support of medication adherence and education.

The NotifiUs software platform today allows friends, family, and medical professionals to schedule SMS Text and Text to Voice messages to remind a patient to take medication or complete follow up appointments. The system also requires the patient to respond within a defined time frame that a certain action was completed or additional Notification and/or Alert messages will be distributed electronically to other individuals to render assistance to the patient. Lack of medication adherence is a large contributor to the overall $200B cost of unnecessary hospital readmissions.

The system also provides positive messages to patients for completing tasks on a timely basis providing encouragement and added support to the patient.

Questions:

- Will DMAS make available a test group of Commonwealth Medicaid patients to participate in a trial of this service?
- Will DMAS provide access to API's for integration of mobile alerts with current Medicaid patient records?

Areas addressed : 3.4 Transformation Step #4: Redesign How DMAS Pays for Services

Related Background and Suggested approach:

A key leader of GMU Center for Health Policy Research and Ethics has been appointed to the newly formed Physician-Focused Payment Model Technical Advisory Committee.

The committee, which was established by the Medicare Access and CHIP Reauthorization Act of 2015, will provide comments and recommendations to the Secretary of Health and Human Services on physician payment models. The 11 committee members were appointed by the Comptroller General.

“With the shift in physician payments for Medicare, this committee will have the opportunity to help shape what future payment models look like,” said Thomas Prohaska, dean of the College of Health and Human Services.

Much more discussion of the DSRIP payment methodology goals is needed to provide a more comprehensive response to item 3.4. But GMU has vast experience with payment models at the state and federal level.

Advocate: Glen “Skip” Skinner

October 16, 2015
Glen 'Skip' Skinner,
Executive Director, LENOWISCO Planning District Commission,
372 Technology Trail Lane, Suite 101,
Duffield, VA 24244
(276) 431-2206

I am healthcare stakeholder. Not only do I depend upon health care for quality of life, I serve as a member of the Wellmont Health System Board of Directors. We are currently engaged in a strategic solutions process that hopefully will result in the merger of two non-profit health systems serving Southwest Virginia and Upper East Tennessee. Beyond these stakeholder issues, the whole region is a stakeholder because of the intersection of health care and economic development. We will not be unsuccessful as we transition our economy away from one dominated by resource extraction to one founded on sustainable economic development principals unless we recognize the importance of health and health improvement as an economic driver for a healthy workforce. A healthy workforce also must include oral health as part of comprehensive health services. I wholeheartedly recommend that DMAS incorporate oral health as a component of each transformation step outlined in the DSRIP application in a complementary way to ensure the following: providers are knowledgeable about the importance of oral health; individuals enrolled in Medicaid have access to oral health education and referrals; and, the care delivery infrastructure supports full oral health integration of adult Medicaid dental benefits when they are realized.

Thank you for the opportunity to comment.

Advocate: Institute for Public Health Innovation

Public Comment: Developing Delivery System Transformation in Virginia's Medicaid System
October 15, 2015

The Institute for Public Health Innovation (IPHI) submits the following comments for your consideration.

3.1.1 Team-based, Integrated Behavioral Health and Primary Care

- We recommend that community health workers (CHWs) be utilized as an integral component of the clinical teams that provide care within the integrated service delivery system.
    - The American Public Health Association defines a community health worker (CHW) as a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.
    - Over the past decade, numerous published studies examining CHW services, outcomes, and cost-effectiveness showed promising results, including studies looking at health care utilization/maintenance or chronic disease management.
    - A February, 2014 randomized clinical trial found that CHW interventions improve access to primary care, quality of hospital discharge, and post-hospital outcomes while reducing recurrent readmissions in part by impacting behavioral and socioeconomic determinants of health.[4] CHW interventions have demonstrated a return on investment ROI from 3:1 to over 15:1 in various studies.[5]
- Long-term sustainability of CHWs can be achieved by taking advantage of a recent CMS rule change that allows for reimbursement of preventive services provided by unlicensed providers under the order of a licensed provider. DMAS would need to include this change in the pending state plan amendment in order for it to apply to providers in Virginia.

3.1.2 Mobile Care Teams

- CHWs are ideal members of mobile care teams because CHWs routinely work with patients, clients, and community residents in the neighborhoods in which they live. The relationships of trust and mutual support that CHWs are able to make with communities are tremendous assets in improving quality of care and outcomes.

3.1.3 Care Transitions and Diversions from Institutional Care

- Based on the references provided above, CHWs would be valuable additions to clinical teams in order to support care transitions.

[4] Kangovi, S, et al, (2014) "Patient Centered Community Health Worker Intervention," Journal of the American Medical Association. Retrieved from http://archinte.jamanetwork.com
[5] Rush, Carl H. Return on Investment from Employment of Community Health Workers. J Ambulatory Care Management. April-June 2012, Vol 35, No 2, pp. 133-137.

3.1.4 Addressing Super-Utilizers

- Based on the references provided above, CHWs would be valuable additions to clinical teams in order to work with super-utilizers, reduce unnecessary care, and promote appropriate utilization of care. Many of the challenges faced by super-utilizers are social and economic in nature, and CHWs are trained specifically to help their clients navigate the various systems through which services and support can be obtained to improve quality of life and healthcare outcomes.

3.3.1 Training

- In addition to training providers to integrate behavioral health into primary care and to work effectively with people of all ability levels, it is also imperative to assure that providers are able to effectively work with people of diverse racial, ethnic, socioeconomic, sexual orientation and identity backgrounds. Training should also build skills in working with patients with limited health literacy and identifying and addressing social and economic barriers to good health within the clinical setting. Such training can be provided through in-person and/or distance learning trainings. Providing CEUs and making the participation in training part of the Medicaid Managed Care contracts would assure participation.
- Integrating CHWs into clinical care models will require multiple levels of training. CHWs require training and ongoing continuing education to effectively perform their duties. In addition, traditional members of clinical care teams (MDs, RNs, NP, PharmD, SW, etc.) require training to understand the unique roles of CHWs and to effectively integrate them into the team.

3.3.3 Telehealth

- CHWs' roles are ideal for utilizing telehealth. Because they work with clients in their homes and communities, they could be trained to operate audio and video technology to link clients/patients to primary care and specialty care providers.

3.3.4 Housing and Employment Support

- There are models that effectively link patients to housing and employment needs:
    - Health Leads—A model that originated in Boston, MA. Health Leads integrates training for clinicians on identifying social and economic barriers to health and adherence to treatment (e.g. food access, affordable housing, heating assistance, child care). Clinicians then write prescriptions for resources and services and onsite staff link patients to those resources.
    - Medico-legal partnership—A model that has been used extensively in Boston, MA, as well as other regions. Clinical practices partner with attorneys to address legal issues faced by patients that are barriers to health and adherence to care (e.g. landlord-tenant issues, taxes, criminal justice).
- CHWs' roles are also ideal for providing housing and employment support. Again, CHW expertise is in building relationships and developing an understanding of assets and challenges, and helping clients navigate those challenges. Many of the challenges are related to housing and income/employment.

Overarching Comments Regarding IPHI and its Capacity to Support Delivery System Transformation

IPHI creates partnerships across sectors and cultivates innovative solutions that improve health and well-being for populations and communities across Virginia, Maryland, and the District of Columbia,

particularly those most affected by health inequities. Our work strengthens service systems and public policy; enhances the environments and conditions in which people live, age, work, learn, and play; and builds organizational and community capacity to sustain progress. IPHI is one of 44 member public health institutes within the National Network of Public Health Institutes (NNPHI) and the official public health institute serving Virginia, Maryland, and the District of Columbia.

Public health institutes are non-profit organizations with a unique and important function in the public health and health care infrastructure. Public health institutes are designed to serve as neutral conveners, facilitators, and intermediaries that work across the many sectors that have roles to play in producing health. In particular, public health institutes are meant to extend the capacity of the public health system while enabling effective collaboration across government, the medical sector, community-based organizations, academia, the business community, and others. IPHI's functions include convening diverse partnerships and leading innovative public health interventions, providing technical assistance to government and community organizations, training the health workforce, supporting effective public policy, and conducting research and evaluation.

IPHI possesses the expertise in the following areas, which align with DSRIP priorities:
1. IPHI has become particularly known in our region and nationally for our work developing the community health worker (CHW) workforce. IPHI is one of the Virginia- DC-Maryland region's leading partners in the development, coordination, and evaluation of CHW initiatives. IPHI is engaged in a range of activities from training CHWs, to coordinating and evaluating CHW-based services, to leading broader community and policy workforce development efforts. With respect to CHW training, IPHI has trained over 350 CHWs over the past 5 years.

2. IPHI has experience developing and conducting training and providing technical assistance to medical, public health, and human service providers to increase their ability to effectively promote health equity and address social and economic barriers to good health. Our expertise could be utilized to develop training modules for Medicaid Managed Care Organizations and medical providers to increase their abilities to work effectively with diverse populations and to address social and economic barriers (including housing and employment) experienced by their patients.

Advocate: Karen Kallay

Subject: Concern about apparent limited role of patients in plans to integrate data and service

This comment is based on:

- My multi-year experience as a volunteer advocate for improved healthcare systems (see below)
- My attendance at the mid-Sept 2015 presentation in Fredericksburg about DSRIP et al

My concern is that I saw no mention of explicitly including patient-citizens in the resulting digital integration process. Patients/citizens need to have as much access as possible to their personal records so that they can:

1. Better participate in decisions about their healthcare. (quality healthcare)

2. See the full costs, whether as co-payers, insured individuals, or as taxpayer. (transparency and cost-sharing)

I realize that providers are leery of this. Certain exceptions can be specified. Copies of lab results can be accompanied with referrals to sources of caveats, explanations and background

Your consideration of this will be appreciated.

Sincerely,

Karen Kallay

(540) 373-1744 (c) 845-5545

kakallay@gmail.com

Member of (and not speaking for) the following: Governing Board of Rappahannock Area Community Services Board; Western State Hospital Citizen Advisory Council; Mary Washington Healthcare Citizen Advisory Council, Behavioral Health Group; Recovery in Motion, President; Virginia Organizing; Mental Health America; National Alliance on Mental Illness-Rappahannock Affiliate, VP Presentations

Advocate: Northern Virginia Health Foundation

October 14, 2015

Ms. Cindi Jones, Director
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

Dear Ms. Jones:

The Northern Virginia Health Foundation, which seeks to improve the health and healthcare of low-income residents of Northern Virginia, supports DMAS's efforts to transform the Medicaid delivery system by focusing on improving the care experience for the Commonwealth's most vulnerable residents. The Foundation recognizes that the DSRIP funding cannot cover services nor new populations and that Medicaid coverage for adults with oral health needs is very limited. However, "whole person care" and "integrated services" should include oral health care. The Foundation recommends that DMAS, to the extent possible, incorporate oral health into this proposal.

Sincerely,

Patricia N. Mathews
President and CEO
Northern Virginia Health Foundation

Advocate: Richard Schultz

Adults with Intellectual and Developmental Disabilities Face Many Challenges Accessing Oral Health Care in Virginia

As a healthcare stakeholder, I wholeheartedly recommend that DMAS incorporate oral health as a component of each transformation step outlined in the DSRIP application in a complementary way to ensure the following: providers are knowledgeable about the importance of oral health; individuals enrolled in Medicaid have access to oral health education and referrals; and, the care delivery infrastructure supports full oral health integration of adult Medicaid dental benefits when they are realized.

In my role I work with adults with intellectual disabilities, and I have seen first-hand the grim future these individuals face as it relates to their oral health care needs. Those individuals who need oral health care currently face two major obstacles. First, there is a serious shortage of dentists trained to serve this population, and second, lack of funds to pay for these desperately needed services are significantly limited.

While work is underway in Virginia to increase the number of dentists trained to serve this population – thanks to the efforts of organizations such as the Virginia Oral Health Coalition - the longer road ahead is to secure funding to pay for the oral health care needs of those with intellectual and developmental disabilities.

These individuals rely on Medicaid as their primary source of funds to pay for oral health care. Unfortunately, once these individuals reach adult age, Medicaid will only pay for emergency extractions. Any other work is either not performed or the individual must find other financial resources to pay for needed care.

According to the National Institutes of Health, in general people with an intellectual or developmental disability have poorer oral health and oral hygiene than those without this condition. Data indicates that people who have an intellectual disability have more untreated cavities and a higher prevalence of gingivitis and other periodontal diseases than the general population. Left untreated, these issues can lead to more serious health problems.

According to a US News and World Report article entitled, "Dental Woes Abound for Developmentally Disabled: Study," one-third of this population has untreated cavities, 80 percent have gum disease and 10 percent are missing some of their teeth. The reasons for this are many - some may not have the cognitive ability to care for their teeth, others have physical limitations and others may have behavioral limitations. The issue is further complicated by the fact that so many people with ID are also economically and socially disadvantaged. There is increased evidence showing the direct link between good oral health and a person's overall health. By proactively providing the oral health care that these individual's need, we can prevent more serious problems that may occur later in their life.

The fact that this population is not treated the same as the general population with regard to their oral health is simply not acceptable. Because this vulnerable population experiences a number of health-related issues, access and funds to pay for quality oral health care are critical. This issue can no longer continue to be ignored by the Commonwealth of Virginia and the state agencies that are charged with supporting this population.

Richard S. Schultz
Former Executive Director of SupportOne

Advocate: Virginia Board for People with Disabilities

October 16, 2015
TO: Karen E. Kimsey, MSW
Virginia Department of Medical Assistance Services (DMAS)
DSRIP@dmas.virginia.gov
FROM: Heidi L. Lawyer

RE: DSRIP Concept Paper Comments

I am writing on behalf of the Virginia Board for People with Disabilities (the Board) to comment on the Virginia Medicaid Delivery System Reform Incentive Program (DSRIP) Concept Paper titled Accelerating Delivery System Transformation in Virginia's Medicaid Program. The Board appreciates DMAS's efforts to transform Medicaid in Virginia into a system that encourages and rewards high value acute and long-term care, increases community capacity, improves provider expertise, and ensures person-centered, community-based care. We agree that provider reimbursement based on utilization is not effective and, in fact, can incentivize unnecessary care, as opposed to preventive care and supports. We would like to work with DMAS as the DSRIP plan is developed and ultimately implemented. We are interested in participating in any of the stakeholder workgroups going forward. In particular, we would welcome the opportunity to participate in those related to workforce development and training, housing, employment, and care transitions/diversions from institutional care.

While we provide comments on specific elements of the DSRIP Concept Paper below, the Board feels compelled to offer words of caution about the DSRIP plan in general at the outset: Medicaid is currently undergoing significant changes in Virginia, from Medicaid Waiver redesign and transition to managed care to implementation of the DOJ Settlement agreement. While the DSRIP plan covers a broader population than most of these changes, there is significant potential for overlap between these initiatives. It has been noted elsewhere, for instance, that the goals and strategies of managed care and integrated care overlap. This could present significant problems for Virginia in determining value-based reimbursement schemes, because it could become very difficult to disentangle the various changes to determine which change an improved outcome ought to be ascribed. The Board encourages DMAS to consider very carefully how DSRIP fits into the broader picture of Medicaid reform in Virginia, and if it can reasonably be accomplished along with all of the other ongoing changes. The Board further encourages DMAS to consider a phase-in approach to DSRIP implementation, where DSRIP initiatives could be piloted in specific localities to ensure their workability prior to expanding to statewide implementation.

The Board believes that any change to Virginia's system of Medicaid services should ensure that people with disabilities have access to person-centered services and supports that are delivered in the most integrated setting appropriate to their needs and in a manner that allows for maximum consumer choice and control, and which are available to all people with disabilities regardless of where they live. In light of these goals, the Board offers the following comments on specific elements of the DSRIP Concept

Paper. Per the instructions provided in the Concept Paper, comments are organized according to the numerical references within the Paper itself.

3.1.1 Team-based, Integrated Behavioral Health and Primary Care

The Board supports DMAS's goal of making holistic, person-centered, community-based care the standard practice for Virginia's Medicaid enrollees. However, the Board urges DMAS to ensure meaningful consumer choice can coexist with integrated care models. The Board strongly believes that individual choice and control should be guiding principles in the design of Virginia's Medicaid system. The Board encourages DMAS, therefore, to ensure that behavioral health and medical care integration is not achieved at the expense of meaningful consumer choice and meaningful consumer control over one's own medical and behavioral healthcare, and one's choice of providers.

The Board notes that the integration of behavioral health and primary care requires specialized knowledge of both of these systems, and must be driven by people who possess this unique expertise. The Board encourages DMAS, therefore, to identify entities that are already engaged in the delivery of integrated care, such as an effective Person-Centered Medical Home, and tap into the expertise of these providers to drive the expansion of this model. This expansion will likely require a gradualist approach, because the amount of training and internal systems change necessary to carry it out will be extensive.

3.1.2 Mobile Care Teams

The Board supports the multiplication of mobile care teams, particularly in rural settings where a lack of providers and limited transportation options are barriers to accessing medical and behavioral healthcare. These teams should be provided specialized training in the unique needs of individuals with significant disabilities that prevent them from traveling to a medical facility. The Board encourages DMAS to focus its investments in mobile care teams to areas with known shortages of healthcare providers and limited transportation options for people with mobility-related disabilities.

3.1.3 Care Transitions and Diversions from Institutional Care

The Board strongly supports DMAS's efforts to increase successful transitions from institutional to community settings. The provision of care in the most integrated setting appropriate to an individual's needs should be a foundational principle underlying the delivery of services to people with disabilities. The Board strongly supports, therefore, use of evidence-based practices, such as the Coleman Model, to avoid unnecessary institutionalization of individuals with complex medical and behavioral health needs and to facilitate successful transitions from institutional to community settings.

3.1.4 Addressing Super-Utilizers

The Board supports the implementation of protocols that increase access to primary care and care coordination by those who frequently use emergency department services. The Board urges DMAS to encourage creative solutions by providers that address the root causes of super-utilization of emergency services. Such causes are varied and may include serious illness, lack of access to primary care, poverty, or unmet behavioral health needs. The Board encourages DMAS to ensure that efforts aimed at curbing

super-utilization of emergency medical services align with the values of person-centered care and maximum consumer choice and control.

3.2 Transformation step #2: Build a Data Platform for Integration and Usability

The Board encouraged DMAS to focus significant efforts on developing effective data systems early in the DSRIP Waiver period. Data collection and data sharing will be central to the successful implementation of the DSRIP Concept. Value-based payment systems rely upon reliable data that allows benchmark and peer-to-peer comparisons. Additionally, efficient provider collaboration requires the capacity for providers to share necessary information in real time. Other states who have been awarded DSRIP grants have struggled with decentralized approaches to data collection. California, for instance, ultimately settled on using the national Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as a tool for comparing care systems. The Board recommends that DMAS consider whether an existing data platform, such as CAHPS, could be adopted to ensure uniformity and compatibility of data collected.

3.3 Transformation Step #3: Build Community Capacity

The Board supports DMAS's community capacity building strategies. We especially applaud DMAS's inclusion of housing and employment as critical elements of its capacity building plan. The Board encourages DMAS to go further than its capacity building plan by including integrated, competitive employment outcomes for individuals with significant disabilities within its value-based payment metrics for Long Term Services and Supports (LTSS) (discussed further below). Additionally, the Board strongly urges DMAS to add transportation as an additional element of its capacity building plan.

Transportation is vital to living a healthy and fulfilling life in the community. Reliable transportation is essential to maintain housing, access healthcare services, and shop for healthy groceries. Yet, people with disabilities too often lack reliable means of transportation. DMAS should, therefore, include transportation among its community capacity building objectives. Specifically, DMAS should incentivize and facilitate coordinated community development that links housing, transportation and services. Additionally, DMAS should facilitate local transportation planning that includes consideration of the transportation needs of people with disabilities.

3.3.3 Telehealth

The Board commends DMAS's efforts to expand access to healthcare, especially preventative and behavioral healthcare, for people with disabilities, including through expansion of the delivery of these services via telecommunication technologies (telehealth). While the advantages and disadvantages of telehealth have been explored in a number of contexts in recent years, it is worth noting that the use of telecommunication technologies for the delivery of behavioral healthcare is a fairly new phenomenon, the risks, benefits, and limitations of which are still being explored. The Board, therefore, encourages DMAS to ensure that as it promotes the use of telehealth to deliver behavioral health services to people with disabilities, it does so in a way that is supported by research and in accordance with best practices.

The Board also encourages DMAS to collaborate with relevant regulatory boards, such as the Virginia Board of Psychology, and the Virginia Board of Counseling as it plans its behavioral telehealth promotion activities. Current regulatory guidance on the appropriate use of telehealth by behavioral health providers is either nonexistent (Board of Psychology),1 or very restrictive (Board of Counseling).2 This current lack of regulatory clarity is a disincentive to provider participation in behavioral telehealth. Any telehealth capacity building strategy should, therefore, include clarification of and education about the regulatory and ethical issues involved in its use.

3.4.1 Initial Payment Strategies

The Board encourages DMAS to include quality-of-care outcomes among its value-based care metrics. Quality-of-care metrics would include, for example, competitive, integrated employment outcomes for people with significant disabilities, successful transitions from institutional settings to community settings, and consumer satisfaction/consumer experience metrics. The Board supports DMAS's efforts to move Virginia towards a system where providers are reimbursed for high *quality* care rather than for high *quantities* of care. The Board also supports DMAS's gradual approach to moving towards a value-based payment system. The Concept Paper indicates that DMAS will "include initial value-based payment standards in its upcoming MLTSS program," in its efforts to begin to work with providers to ensure that policies are developed for successful implementation of the value-based purchasing program. The Concept Paper does not indicate what these initial value-based payment standards will include, but it does identify cost-reduction goals of the DSRIP plan, such as reduction of emergency medical care utilization, and reduction of re-admissions. The Board encourages DMAS to ensure that quality-of-care is prioritized over simple cost reduction by establishing quality metrics.

Given the importance of metrics to a successful value-based payment scheme, the Board encourages DMAS to carefully plan this element of the DSRIP project. Specifically, the Board encourages DMAS to convene workgroups to develop proposed outcome metrics. As a starting point, however, the Board believes that value-based repayment metrics should be developed for multiple levels of healthcare outcomes, including individual outcomes, program level outcomes, provider outcomes, and systems level outcomes. Additionally, DSRIP metrics should reflect the ultimate goals of the services being provided. In the case of LTSS, these goals ought to include the provision of high quality services that promote independence, delivered in the most integrated setting appropriate to the individual's needs and in accordance with person-centered principles. The Board, therefore, strongly urges DMAS to include metrics that measure providers' success in achieving these goals in its initial value-based repayment standards. At a minimum, such standards should incentivize successful transitions from institutional to community settings, successful attainment of integrated, competitive employment, and delivery of services in a manner consistent with the individual's preferences and goals.

Thank you for this opportunity to comment on the DSRIP Concept Paper. The Board would very much appreciate additional opportunities to participate in future discussions about these initiatives, as well as to be included in any workgroups convened to plan and/or monitor the development and implementation of the DSRIP plan.

Advocate: Virginia Oral Health Association

To: Cindi Jones, Director, Department of Medical Assistance Services

From: Sarah Holland, Executive Director, Virginia Oral Health Coalition
Tegwyn Brickhouse, VCU Department of Pediatric Dentistry, Virginia Oral Health Coalition Legislative Committee Chair
Robin Haldiman, CEO, Chip of Roanoke Valley, Virginia Oral Health Coalition Board Chair

RE: DSRIP Public Comment

The Virginia Oral Health Coalition is pleased to provide comment on the Commonwealth of Virginia's concept paper "Accelerating Delivery System Transformation in Virginia's Medicaid Program."

Given the strong relationship between oral health and overall health, particularly the connection between poor oral health and diabetes, adverse pregnancy outcomes, pediatric health, and emergency department visits, the Virginia Oral Health Coalition strives to integrate oral health into all aspects of health and wellness.

We commend the Department of Medical Assistance Services' decision to focus the DSRIP activities on the costliest and most vulnerable Virginians; the complexity of their health needs is tremendous and both these patients and the Commonwealth will benefit if the DSRIP goals are realized.

The integral relationship between oral health and overall health is well-documented and was emphasized during the SIM (State Innovation Model) planning process in two key areas: as one of the high-level indicators that will demonstrate achievement of the vision and transformational goals of SIM, and as a key improvement area. Yet, despite this recognition, it is not mentioned in the DSRIP description provided for public comment. We believe, as the SIM planning process emphasized, that oral health is a necessary component of person-centered healthcare. Many of the individuals who will receive care as part of the DSRIP program will have health issues that have an association with poor oral health (for example, diabetics have issues related to dry mouth).

We understand that only dental services currently covered by Medicaid (limited to tooth extractions for non-pregnant adults) can be included in the DSRIP program design. Despite this limitation, we strongly believe providers and patients will benefit if oral health is woven into the current DSRIP framework in a complimentary manner; the integration of physical and oral health aligns with and complements the concept paper's focus on behavioral and physical health. We are not suggesting an additional transformative goal - simply a recognition of areas where oral health fits within existing goals.

To that end, please find our recommendations below.

3.1 Transformation Step #1: Integrate Service Delivery

3.1.1 Team-Based, Integrated Behavioral Health and Primary Care
Many Federally-qualified Health Centers (FQHCs), health systems and private practices, recognizing the need to provide holistic, comprehensive care for patients, are integrating oral health into patient-centered care models with great success, despite reimbursement and funding barriers. For example, The Daily

Planet, a Richmond-based community health center, has integrated oral health into their patient-centered medical home care model by bringing together dental and medical clinicians with administrators and community partners to integrate bi-directional comprehensive care for the clinics diabetic patients that includes oral health. A key to successful integration is interdisciplinary care teams that include primary care, behavioral health and oral health. While we recognize that many Medicaid enrollees do not have comprehensive dental benefits, the tide is shifting; eventually dental and medical will have parity. To that end, we think it is imperative that oral health be woven into the integration infrastructure in ways that are complimentary to the DSRIP goals and feasible, given the current coverage realities. We strongly recommend that, whenever possible, care teams include oral health providers to ensure all aspects of a patient's health care needs are respected. Additionally, we recommend that care teams who choose to integrate oral health beyond the confines of the DSRIP waiver are not stymied. If true holistic, person-centered care is to become standard practice for all Medicaid enrollees, oral health is as vital as behavioral health.

3.1.4 Addressing Super-Utilizers

Hospitals across the Commonwealth report significant costs related to emergency department (ED) use for dental issues, for example, VCU Medical Center's emergency department reported that over 4% of ED visits were attributable to dental issues between 2007-2009. Rural hospitals report similar numbers, with a small rural hospital reporting over 2% of its ED visits attributable to dental. A burden large enough to prompt the hospital to start its own safety net dental clinic. A component of the protocols designed with DSRIP funding should include appropriate education of ED staff and providers regarding oral health issues and a referral mechanism to reduce the reliance on the ED for dental issues. VIPs could choose to implement components of the ED diversion model developed by the oral health and primary care integration workgroup convened as part of the Commonwealth's SIM work. Additionally, ED visits for dental issues may be associated with individuals seeking opioid drugs for recreational use and an increased reliance on narcotics - a further reason to address the issue through education, diversion and referral as part of overall Medicaid reforms. Physicians treating patients in an emergency room have little-to-no resources, other than providing a patient with pain medications, including narcotics. If Medicaid-enrolled adults continue to lack a comprehensive dental benefit, ensuring ER diversion programs include a remedy that provides the physician a means to divert dental patients seeking narcotics will help address the rising opioid addiction epidemic.

3.2 Transformation Step #2: Build a Data Platform for Integration and Usability

3.2.1 Data System Development within VIPs

Many of the organizations likely to become VIPs offer dental services in addition to primary care services. To that end, data platforms that include all of a patient's health information, including dental records, are necessary to truly ready providers to conduct team-based care, be reimbursed for outcomes, exchange data in real-time and utilize data analytics. Additionally, if dental records are not included in infrastructure development from the beginning, when coverage and reimbursement for dental services is achieved, retroactive integration of data systems will be costly and cumbersome.

3.2.2 Providers Link to a Statewide Care Management System

We strongly recommend, to support all person-centered care efforts, that data from Virginia Medicaid's dental program Smiles For Children be included in any care management system.

3.2.3 Statewide Set of Minimum Data Standards

Oral health is associated with multiple chronic conditions and adverse health outcomes in individuals across the lifespan; improved oral health is shown to improve hemoglobin levels in diabetics, pregnancy outcomes and pediatric health. A key component to integration of health care services is data and measurement that are consistent and enable providers to better understand the health and environment of their patients. We recommend the DSRIP minimum data standards mirror those determined by the Lt. Governor's Roundtable on Quality, Payment, and Health Information Technology convened as part of the Commonwealth's SIM work. This workgroup has demonstrated a thoughtful approach to measurement that we believe will be in-line with the DSRIP goals.

3.3 Transformation Step #3: Build Community Capacity

We applaud the focus on population health and community capacity in the DSRIP application and recommend including oral health as a component of community capacity. While comprehensive dental coverage does not exist for most of the target population of the DSRIP waiver, Virginia does have a network of safety net providers and avenues for charity care. While the safety net cannot adequately meet the needs of those in need of care, it can be an avenue of care for many. Because many medications cause dry mouth and other issues which significantly increases the risk of caries (cavities), erosion, tooth loss, mouth infections, loss of taste, and difficulty chewing and swallowing, which can then lead to poor nutrition and failure to thrive, it is imperative that patients (and providers) understand the resources available in both safety net and charity care to relieve the burden of poor oral health.

3.3.1 Training

We recommend that all integration trainings include information about oral health and appropriate referral sources for oral health care. We understand and respect that oral health services are not a focus of the DSRIP application. However, if simple information about the relationship between oral health and overall health (including medication side-effects) and referral sources are included as a piece of the overall integration education, patient self-care will increase, health outcomes will improve, and, when dental benefits are included as part of Medicaid coverage for all adults, comprehensive integration will face fewer barriers.

Additionally, this provides a key opportunity to include dental providers in trainings to ensure they are comfortable treating individuals of all ability levels. Currently, a very limited number of dentists feel comfortable treating persons with disabilities, which makes it exceedingly difficult for these Medicaid patients (children and adults) to access necessary dental services. Providing appropriate training for dental providers will improve access to care for these vulnerable and often costly Medicaid patients.

3.3.4 Housing and Employment Support:

We applaud the fact that the DSRIP application recognizes the importance of community supports and referrals for housing and employment resources. As referenced before, safety net clinics offer dental services for underserved individuals, and other charity programs exist to ensure low-income individuals get necessary dental treatment. We recommend adding referral support for oral health services as an additional strategy. We also suggest including information about access to oral health services for the underserved in the data platform created to ensure case managers, providers and other team members of the VIPs are able to better meet the needs of Medicaid beneficiaries.

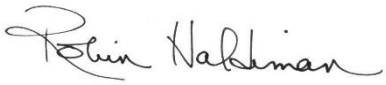
Thank you for the opportunity to provide comment; we look forward to an ongoing effort to ensure that

person-centered health care is the norm for all Medicaid beneficiaries. We are happy to provide any additional information or resources, or answer any questions.

Sincerely,

Sarah Bedard Holland
Executive Director, Virginia Oral Health Coalition

Robin Haldiman
CEO, Chip of Roanoke Valley
Virginia Oral Health Coalition Board Chair



Tegwyn Brickhouse, DDS
Virginia Commonwealth University, Department of Pediatric Dentistry
Virginia Oral Health Coalition Legislative Committee Chair

QUESTIONS: N/A
CONTACT INFORMATION:
Sarah Bedard Holland
4200 Innslake Drive, Suite 103
Glen Allen, VA 23060
(804) 269-8721
sholland@vaoralhealth.org

Provider Comments

Provider: American Academy of Pediatrics

On behalf of the Virginia Chapter, American Academy of Pediatrics, we are pleased to have a chance to submit our preliminary comments on the proposed Delivery System Reform Incentive Payment Program (DSRIP) based on the concept paper and the first focus group that was held on October 7th.

We know the amount of work that has gone into preparing this grant application by the Department of Medical Assistance Services (DMAS) and are appreciative of their commitment to identifying new ways of delivering integrated and more efficient care for Virginia's Medicaid patients.

Integrate Service Delivery/Expand Community Capacity

The VA AAP recognizes that the unmet mental health needs of young children, especially those who have not yet entered school, are great. We are committed to addressing the mental health needs of diverse children and their families through culturally competent and family focused initiatives. Our goal as pediatricians is to improve the integration of mental health in pediatric primary care for children in the Commonwealth, paying particular attention to the needs of infants, toddlers and preschoolers.

In addition, we are working to ensure that part of our work to integrate mental health in primary care will be to focus on the issue of Adverse Childhood Experiences (ACEs), also called Toxic Stress, and Trauma Informed Care.

We recommend expanding the current program at the Department of Behavioral Health addressing children's mental health to include more funds for training and educating pediatricians on how to recognize and appropriately refer their patients who are struggling with mental health issues, including toxic stress. One of the ways we would encourage DSRIP to achieve this goal is by creating a Mental Health Access in Pediatrics program that would do the following:

- Create consultation team(s) that provide clinical consultation to pediatricians to enhance their abilities to evaluate, treat, co-manage and refer children with a wide range of mental health issues,
- Services would include live phone consultations with child mental health experts (psychiatrists, psychologists, LCSWs, depending on the question) within 30 minutes;
- Brief, time limited follow up services as clinically indicated;
- Resource guide maintenance
- Psychotropic Monitoring Group
- Pediatric practices would enroll in the program for free

We also strongly encourage Virginia to further expand ways to reimburse primary care and pediatric practices for coordinating their patients' care, especially when it comes to mental health services. We know this is an area that has gained more attention recently, but it is an area we strongly support.

Telemedicine

Another very critical part of expanding access and increasing community capacity also includes data integration and continued support of expanding telemedicine access.

The VA AAP is currently working on a grant to implement telemedicine services in eight pediatric practices across the Commonwealth. Our goal is to expand the medical home and access to our current patients by enhancing the ways we can deliver care to our patients. Our goal is to use telemedicine to provide better access to care coordination, while also overcoming barriers to manage chronic care conditions, such as our patients who struggle with transportation issues.

We strongly support DSRIP focusing on the expansion of telemedicine services within current physician practices with their Medicaid patients. The medical home is a critical component to better integrated and more efficient care and we encourage DMAS to identify ways to help practices expand their capabilities with their current patient population.

Finally, to echo similar comments submitted by the Medical Society of Virginia, we do have some overall reservations about creating a new layer of administration when it comes to payment. We are concerned that adding such a layer will not create the type of cost savings nor service delivery efficiencies it purposes to accomplish. Its concerning to think that adding another layer on top of the current MCO structure will create cost savings without reducing the reimbursement of the providers, especially at a time when we need to expand the way we reimburse for care coordination and telemedicine. Virginia's pediatricians already struggle with our low reimbursement, especially in the Northern Virginia region where there is no cost of living adjustment like Medicare provides.

Finally, the DSRIP concept paper specifically indicates that scope expansions are part of the overall strategy for achieving system reform. Without any further details, we also echo MSV's concern about advocating for changes in scope of practice for practitioners within the context of DSRIP. We prefer that conversation to occur outside the context of this grant application.

Again, we appreciate the opportunity to preliminarily comment on Virginia's DSRIP grant application. We look forward to continuing to be a part of the conversation as the plan moves ahead and continue to collaborate with you.

Provider: American Dental Hygienists' Association

TO: Cindi Jones, Department of Medical Assistance Services

FROM: Michelle McGregor, RDH, BS, M.Ed.

RE: DSRIP Public Comment

The Virginia Dental Hygienists' Association (VDHA) kindly requests that the Department of Medical Assistant Services (DMAS) incorporate oral health care as a component of each transformation step outlined in the DSRIP application. Oral health care is vital to the overall health of an individual particularly to Virginia's most vulnerable patients. The patient-centered medical home is only viable with the integration of oral health care as poor oral health care has an effect on adverse pregnancy outcomes, diabetes and systemic emergency department visits.

Thank you for the opportunity to provide comment and we appreciate DMAS working to make patient-centered health care the focus for new payment and delivery models in Medicaid.

Please contact VDHA Advocacy Coordinator, Cal Whitehead at (804) 389-2825 or cal@commonwealthstrategy.net

Provider: Bay Aging and Eastern Virginia Care Transitions Partnership (EVCTP)

Ashley Hazelton
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

October 19, 2015

Dear Ms. Hazelton:

Bay Aging and Eastern Virginia Care Transitions Partnership (EVCTP) appreciate the opportunity to provide comments on the DSRIP proposal. Studies show that 70% of determinates of health are based on socio-economic factors and health behaviors that occur in the home. This makes Area Agencies on Aging (AAAs) the logical partner to address the physical environment, health behaviors, social and economic factors in pre- and post-acute healthcare. The EVCTP Care Transitions model is incorporating innovations such as telehealth, behavioral health and other evidence-based programs to advance health outcomes and meet the Triple Aim. We appreciate your inclusion of the AAAs and Care Transitions Intervention within the DSRIP proposal.

Thank You,

Kathy E. Vesley-Massey
President/CEO
Bay Aging and Eastern Virginia Care Transitions Partnership (EVCTP)
PO Box 610, Urbanna, VA 23175
(804) 758-2386 Ext 1217
(804) 339-1552 Cell
kvesley@bayaging.org
www.bayaging.org

Provider: Carilion Clinic Dental Care

Date: October 16, 2015

To: Cindi Jones, Director, Department of Medical Assistance Services

From: Lee R. Jones, DMD, Section Chief, Carilion Clinic Dental Care

RE: DSRIP Public Comment

Carilion Clinic Dental Care has a long history of providing dental care to underserved populations including those who are medically-compromised, developmentally or intellectually disabled, and HIV infected, along with children who have cleft lip and palate, and disadvantaged and disabled children. We also are strongly involved in education and training of healthcare professionals by way of a Dental General Practice Residency program and leading oral health education for medical students of the Virginia Tech Carilion School of Medicine and Physician Assistant and Nurse Practitioner students of the Jefferson College of Health Sciences.

The proposals enumerated in the Commonwealth of Virginia's concept paper "Accelerating Delivery System Transformation in Virginia's Medicaid Program" are totally in line with the practice and objectives we have followed for years. As a healthcare stakeholder, I wholeheartedly recommend that DMAS incorporate oral health as a component of each transformation step outlined in the DSRIP application in a complementary way to ensure the following: providers are knowledgeable about the importance of oral health; individuals enrolled in Medicaid have access to oral health education and referrals; and, the care delivery infrastructure supports full oral health integration of adult Medicaid dental benefits when they are realized.

Thank you for the opportunity to provide comment and I look forward to an ongoing effort to ensure that person-centered health care is the norm for all Medicaid beneficiaries. We at Carilion Dental are happy to provide any additional information or resources, or answer any questions.

Lee R. Jones, DMD
Section Chief
Carilion Clinic Dental Care

Provider: Medical Society of Virginia (MSV)

Ashley HazeltonOctober | 19 | 2015
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond | VA | 23219

RE: Public Comment on DSRIP

Dear Ms. Hazelton:

On behalf of the Medical Society of Virginia and its 10,753 physician, medical student and physician assistant members, we write to share our feedback on the recently released Delivery System Reform Incentive Payment (DSRIP) concept paper. We have reviewed with great interest the documents and presentations that the Virginia Department of Medical Assistance Services (DMAS) staff has invested a great deal of time, energy and thoughtfulness in preparing. We are appreciative of the department's commitment to identifying new ways of delivering better integrated and more efficient care for Virginia's patients covered through the Medicaid program.

We agree that it is critical that Virginia make needed investments in ensuring a comprehensive and coordinated health care infrastructure that is readily accessible to our patients. We appreciate the department's interest in pursuing innovative opportunities for strengthening that infrastructure. However, we cannot agree that yet another layer of administration and oversight can achieve the innovation and cost savings that are needed to fully offset the federal requirements for cost savings under the DSRIP program. With each insurer's different take on innovation, accountability, value based purchasing, care communities, etc., an entirely new infrastructure is necessary to support the insurer's individual definition of all of the aforementioned. The system that DMAS proposes is yet another hybrid of all of the other "innovations" being imposed on the provider community, seemingly all with good intent but all requiring separate and redundant data, provider and care coordination infrastructures. In this increasingly inefficient environment, we cannot readily see how this plan will truly achieve cost savings absent further decreases in provider reimbursement - reimbursement that is already significantly below Medicare levels. Instead, we foresee another expensive layer of administrative infrastructure that takes funding away from the actual treatment of patients. Therefore, we caution that any planned Medicaid savings required by the waiver be conservative and have truly achievable projections. That way, if the savings do not materialize – as has been the experience in other states – the Medicaid program will not be burdened with re-directing patient dollars to pay back the federal funds.

Further, the DSRIP concept paper specifically indicates that scope expansions are part of the overall strategy for achieving system reform. As you are aware, state law dictates scope of practice and it is not within the purview of a state agency to change those laws. Absent further detail as to the intent of

these expansions, the MSV must oppose scope of practice changes for the purposes of the DSRIP implementation.

Perhaps the most compelling component of the plan as outlined is the involvement of primary care physicians in managing patients' mental and behavioral health care needs. The MSV is fully supportive of this approach and encourages DMAS to institute policy changes immediately that would enable this to occur within the already existing and extensive managed care networks.

We are encouraged to see a stronger focus on coverage for mental and behavioral health, including a commitment to improved access to treatment for substance use disorder, and we appreciate the department's continued interest and willingness to support expansion of telemedicine services. We stand ready to partner with you in these areas. We also continue to offer our assistance in identifying opportunities for streamlining the administrative requirements for participation in the Medicaid program so that you can receive the information you need to administer a strong program and participating physicians and providers can care for their patients in an effective, timely and efficient manner.

We believe that Virginia can be the healthiest state in the nation and we would appreciate the opportunity to collaborate with you in achieving that goal.

With best regards,

Michael Jurgensen

Senior Vice President, Health Policy & Planning

CC: Melina Davis-Martin, Executive Vice President, MSV

Robin Cummings, Director of Health Policy & Research, MSV

Lauren Bates, Senior Director of Health Policy, MSV

Ralston King, Senior Director of Government Affairs, MSV

W. Scott Johnson, Esq., General Counsel, MSV

Provider: Virginia Association of Community Services Boards

Commenter: Jennifer Faison
Affiliation: Executive Director, Virginia Association of Community Services Boards
Date of Submission: 19 October 2015

The Virginia Association of Community Services Boards (VACSB) greatly appreciates the Department of Medical Assistance Services' (DMAS) commitment to stakeholder input on initiatives of importance to the system of care for individuals with behavioral health and developmental disability service needs and offers the below general comments on the Delivery System Reform Incentive Payment (DSRIP) concept paper.

Integration of Service Delivery
The VACSB agrees with many of the limitations in the current system as outlined on pages 3-5 of the DMAS DSRIP concept paper and we believe that CSBs have extensive experience in developing, expanding capacity and creating partnerships around models that work to achieve many of the attributes of the "Transformed System" as charted on page 4 of the concept paper. One example is the "A New Lease on Life" grant projects that partnered CSBs with FQHCs to co-locate primary and behavioral health care and/or share resources. Most of those projects are still in existence and CSBs have embraced the model to the extent that some form of this model is available in 24 localities. Another example is the CSB role in the Commonwealth Coordinate Care project (CCC). CSBs embraced the model and worked closely with the involved managed care organizations to foster strong relationships. In conjunction with this project, CSBs developed Enhanced Care Coordination (ECC) as an overlay on Targeted Case Management (TCM) to ensure that individuals with the most intense combined behavioral health and primary care needs were getting the highest level of support possible, with the CSB serving as the individual's "health home".

The Association is supportive of any move toward a system that both expands upon and improves these types of care coordination models using appropriately aligned financial incentives to underpin strong community partnerships and networks.

Build a Data Platform for Integration and Usability
A value-based payment system is inherently dependent upon good data to support decisions about risk and how to design outcomes. As outlined in the concept paper, DMAS' vision for a data platform is comprehensive and seems geared toward improving outcomes for individuals. VACSB has concerns over the cost impact to providers for moving toward such a system. It could inadvertently impact local decisions (interoperability issues forcing providers to purchase X system vs. Y system) and may also impact CSB budgets in terms of ensuring that they have everything they need to meet the demands of both the VIP structure and the statewide care management system. We are also concerned about whether or not a project with such a large scope can be completed in a timeframe that makes sense within the bounds of the Waiver.

CSBs routinely provide data to DBHDS and have a standardized data set per their performance contracts. We are concerned that there might be duplication between those data points and the ones that DMAS would be collecting and therefore also the potential for duplicated efforts in pulling and/or submitting them in two different systems. Also, with the many data elements that CSBs have to collect and submit to various entities, we are concerned that adding elements without relaxing requirements on other data

elements or removing them altogether, could impact our capacity to manage the data requirements appropriately. A high number of data elements does not necessarily equate to quality and may not help us better understand our system. An appropriate number of high quality measures will.

Build Community Capacity

VACSB believes that in order for any system transformation to be successful, it will be imperative to include workforce development as part of the strategy. While I believe that the training component as outlined on page 10 of the concept paper would be a welcome opportunity for the entire provider community to better understand the needs of all of the populations they serve, it probably does not go far enough to address the severe shortage of workers across the health care system. If there is an opportunity to use DSRIP funding to build critical workforce infrastructure, then that should be included among the goals of the "Transformed System".

We have some confusion over the statement on page 5 of the concept paper that DSRIP funding cannot be used to cover services and how that can be squared against the proposed access to crisis stabilization services and telemedicine services across the state as proposed on pages 10 and 11. The suggestion seems to be that DSRIP funding can support the expansion of those services which is in contrast with the statement on page 5. How can we build community capacity without funding services?

Redesign How DMAS Pays for Services

VACSB's members look forward to learning more about the risk-based models that DMAS plans to pursue relative to DSRIP. We are in the beginning phases of understanding how value-based payments might fit into the existing funding mix for CSBs. Many CSBs receive significant local funding which might complicate discussions about risk-based models for CSBs. In addition, we wonder about how risk will be shared among those in the VIP. It is difficult to envision how, if outcomes are not met, the members of the VIP will determine the root cause for the failure to meet outcomes and therefore determine who would be responsible for any recompense.

VACSB looks forward to continuing the dialogue on DSRIP and is confident that with DMAS' leadership, Virginia will be able to make the most of this exciting opportunity.

Provider: Virginia Association of Family Physicians

Litton Family Medicine, P.C.

J. Scott Litton, Jr., MD, FAAFP
Mona Speak, FNP D. Lynn Carlson, FNP
P.O. Box 646 – Lee Regional Medical Plaza, Suite 7
Pennington Gap, VA 24277 - 276-546-4894

October 14, 2015

TO: Chris Banazak, DMAS Contract Manager
FROM: J. Scott Litton, Jr., MD, FAAFP
RE: Response for VBP

Mr. Banazak,

I have been contacted by our representative from the Virginia Association of Family Physicians to provide input regarding the prospective VBP from Medicaid. I am a member of the VAFP Board of Directors, and we did discuss this topic at our last meeting on October 10. I will provide my comments below.

One point (in two parts) I would make as you discuss Medicaid reform would be access. I understand that many payors are going to be transitioning to a value based or lump payment system in the future. However, any move by Medicaid to further decrease reimbursement to physicians would only place more hurdles to patients in terms of access to physicians. I would hope that through their negotiations of payments that at least two changes could be made for physician reimbursements:

First, for patients that are taking our advice and staying healthy (meaning complying with preventive exams and testing, taking meds as directed, maintaining adequate blood pressure, lipid, a1c control, etc), I would hope that we would be eligible for a bonus for helping to keep these patients out of high cost facilities.

Second, for patients that are more complicated and less healthy (and these are the ones that spending decreases are targeted for), I would hope that our reimbursements would not be decreased as long as we are documenting our advice for complying with treatments and screenings, as well as documenting that our patients are not taking our advice or recommendations as they should. These patients that are using high cost facilities as a result of their non-compliance should be targeted for some sort of financial responsibility (higher ER copayments would be one).

In our remote area in Southwest VA, there are very few physicians to even provide care for these patients. I would hope that the proposed changes will not serve as a hindrance for these patients to get the care they are in need of.

With kindest professional regards, I remain,

Sincerely,

J. Scott Litton, Jr., MD, FAAFP
Litton Family Medicine, P.C.
University of Virginia School of Medicine, Class of 2000

Primary Care For The Entire Family

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Provider: Virginia College of Emergency Physicians (VACEP)

On behalf of the Virginia College of Emergency Physicians, we are pleased to have a chance to submit our preliminary comments on the proposed Delivery System Reform Incentive Payment Program (DSRIP) based on the concept paper promulgated by the Department of Medical Assistance Services (DMAS).

We know the amount of work that has gone into preparing this grant application by the DMAS and are appreciative of their commitment to identifying new ways of delivering integrated and more efficient care for Virginia's Medicaid patients.

One of the biggest challenges for patient care in the emergency department is managing super utilizers. Frequent utilization of the emergency department (ED) is often a sign of serious and complex patient issues and the associated costs are shared by many- the Virginia Medicaid system, the physicians who treat them and the hospitals. Helping these patients get the care they need can be difficult given the complexity of their healthcare needs and their tendency to visit multiple providers, including sometimes multiple EDs.

VACEP encourages DSRIP to examine ways to help manage the care of these super utilizers by partnering with the physicians in the emergency department who treat them to identify the best ways to coordinate their care and ensure they are receiving the best and most appropriate services. Helping these patients get the care they need is crucial and can be achieved if we work together.

From a data integration perspective, we also encourage DSRIP to look at models to connect Virginia's emergency departments to have real time information about their patients. This would be incredibly useful when it comes to managing super utilizers, but it would also help with substance abuse and the current epidemic of prescription drug abuse. One such system that has been deployed in both Oregon and Washington is the Emergency Department Information Exchange or EDIE system that addresses both concerns.

The system is designed specifically for emergency departments and it's designed to work best when all hospitals are on board. DSRIP would be the perfect place to look at such a data integration tool and we encourage you to explore it further.

Here are some details to consider: EDIE is a rapidly deployable ED-based tool by which to coordinate complex patient care by collecting and communicating minimum necessary information, in real-time, across care settings. It integrates within providers' existing workflows to push high-value, actionable insights to ED providers--generally right into their EHR ED tracker board--the moment a high-risk patient presents in the ED. As a care collaboration network, it amplifies the work of case managers by guiding them to a specific set of high-value complex patient management workflows and ensures that the insights from these workflows attach to the patient rather than a particular IT system.

EDIE is deployed across 100% of the hospitals in WA and OR, and is currently expanding across over two dozen additional geographies which ultimately operate as a single, contiguous network irrespective of where high utilizers traverse. On average, EDIE drives a 30-40% reduction in high-utilization visits in the first year after deployment; these visits over index to Medicaid and uninsured patients. Of note, EDIE is the framework underpinning Washington State's complex patient care management efforts which resulted

in a 10% aggregate Medicaid ED visit decline and ~$34M in first-year savings (annual ROI in excess of 30x).

Overall, to echo similar comments submitted by the Medical Society of Virginia, we do have some concerns about creating a new layer of administration when it comes to payment. We are equally as concerned as MSV that adding such a layer will not create the type of cost savings nor service delivery efficiencies it purposes to accomplish. Its concerning to think that adding another layer on top of the current MCO structure will create cost savings without reducing the reimbursement of the providers, especially at a time when we need to expand the way we reimburse for care coordination, not reduce provider payments.

We truly appreciate the opportunity to preliminarily comment on Virginia's DSRIP grant application. We look forward to continuing to be a part of the conversation as the plan moves ahead and look forward to working together.

Provider: Virginia Commonwealth University (VCU) Health System

October 19, 2015

Via E-mail: dsrip@dmas.virginia.gov
Ms. Cindi B. Jones, Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Director Jones:

On behalf of Virginia Commonwealth University Health System (VCUHS), below please find comments that we respectfully submit for your consideration in response to the recently released DSRIP Concept Paper. Please note that feedback has been sought and comments elicited from multiple stakeholders within our organization, including those within our hospital enterprise, the physician practice plan, our Medicaid Managed Care Organization (VA Premier), and those engaged in educating the health care workforce of the future.

We applaud DMAS's effort to accelerate the transformation of its Medicaid delivery system to one that is more quality focused and value-driven. Please know that we share in this goal and are committed to achieving high quality, person-centered outcomes for all individuals that we serve. We would encourage DMAS to consider establishing and convening an executive/steering committee that includes representatives from all major stakeholder groups to assist in the development of the §1115 waiver, as well as in providing feedback throughout negotiations with CMS.

In an effort to provide our comments in the most logical manner possible, we have organized our comments by corresponding Concept Paper sections.

2 – Background

VCUHS agrees with DMAS that a disproportionate share of Virginia's Medicaid spending is allocated towards those enrollees who receive Long-Term Services and Supports (LTSS). While we understand it is DMAS's intent to include the "LTSS" population in the DSRIP initiative, this classification is broad and warrants further clarification. Upon reading the Concept Paper, we have the following specific questions around the intended patient population:

- DMAS references 200,000 individuals in the Aged, Blind, and Disabled (ABD) coverage group.
    - Is it intended that all 200,000 ABDs will be included in the DSRIP patient population? Does DMAS intend to "carve out" acute care for those who are

currently being managed by health plans (approximately 80,000), such that only their LTSS services are "carved in" to the DSRIP?
    - Will DMAS include in the DSRIP initiative all 115,000 ABDs who are dually enrolled in Medicare and Medicaid? Does the 115,000 number include the over 66,000 individuals who were eligible for Commonwealth Coordinated Care (CCC) in June of 2015?
- Are there any other coverage groups/patient populations who can be classified as LTSS, and whom DMAS intends to include in the DSRIP initiative?
- Does DMAS intend to include the "Behavioral Health" population in this initiative? If so, what are their current coverage classifications and associated enrollment numbers?

It would be helpful if DMAS could provide the total number of intended DSRIP participants, including the coverage-type breakdown, and geographic distribution for all participants. A graphic depiction – e.g., a pie chart or the like – would be exceedingly beneficial.

3.1 – Transformation Step #1: Integrate Service Delivery

VCUHS understands that an initial goal of DMAS is to further integrate service delivery by eliminating "silos" of care between providers through the creation of Virginia Integration Partners (VIPs). While we understand the VIP networks will be contractual arrangements between a number of different public and private providers, we have the following questions around the creation, administration, and oversight of the VIPs:

- How will the VIP regions be defined? Will DMAS use existing regions (e.g., through Medallion 3.0 or CCC) to define the geographic parameters?
- Can more than one VIP exist in a designated region?
- Will provider participation be mandatory or voluntary? If voluntary, does DMAS intend to issue either a formal/informal RFP? Along these same lines, will DMAS clearly delineate the criteria that providers must meet to be eligible for participation?
- What is the minimum number of provider participants in the VIP?
    - If the desired minimum is not achieved, will mandatory participation be considered?
- Given that the Medicaid portion of the LTSS spend is primarily focused around nursing homes and those providers rendering home and community-based services, does DMAS intend that these providers will be included in the VIP networks?
- Does DMAS intend to proactively attribute patients to a VIP, or will the VIP be responsible for a defined population of Medicaid beneficiaries who live within the region?
- Please define the role of the managed care organizations (MCOs) in the DSRIP, including how they will interact with the VIPs. Will the MCOs be specifically included in the VIP networks?
- In other DSRIP states, public hospitals have primarily been identified as "Coordinating Entities," in large part due to the critical role that they play in the financing of the DSRIP.

Does DMAS intend to identify the Coordinating Entities, and if so, what are the criteria to serve?
- What infrastructure will be established at the state level to coordinate the activities of the various VIPs and Coordinating Entities?

3.1.3 – Care Transitions and Diversions from Institutional Care

The Concept paper noted that "DMAS will allow Virginia to implement principles of the Coleman Model to increase success when transitioning Medicaid members between care settings." While we are supportive of this concept and believe the implementation of this model has resulted in successful outcomes in many settings, there are other models (e.g., the Naylor model) that may also prove beneficial in supporting Medicaid populations across the Commonwealth. As such, clarification regarding the opportunity to implement other evidence-based models would be appreciated.

3.1.4 – Addressing Super Utilizers

VCUHS has long shared an interest in identifying and assisting those patients who can be deemed "super utilizers." While we agree that affording patients access to a primary care "home" and coaching them to use the overall health care system can help to mitigate improper utilization, experience across VCU Health System clinical settings has shown that these efforts alone are not sufficient to truly change the behavior of a "super utilizer." Most super utilizers have concurrent, systemic issues, which are often associated with social determinants of health such as shelter, heat, food, and safety. Until these underlying issues can be addressed with the proper social supports, it is difficult to positively impact hospital and ED utilization behaviors among this patient population. As such, we would encourage DMAS to consider allowing DSRIP funds to be applied to help offset the cost of social/community supports.

3.2.1 – Transformation Step #2: Build a Data Platform for Integration and Usability

VCUHS agrees with DMAS that the establishment of a robust, interoperable data platform will be critical to the success of the DSRIP program. From the outset, it will be critical for all providers within a VIP network to have access to data that is specific to the population served by the VIP. This baseline data will inform not only the overarching patient outcome goals, but also the particular interventions that are chosen to achieve outcomes. We understand that such data is generally available for those LTSS patients who are currently enrolled in Medicaid fee-for-service, but that the information is not readily available for those populations in managed care or are dually eligible (and therefore much of the hospital/physician utilization data resides with Medicare). To the extent possible, DMAS should attempt to address these data challenges upfront, as the success of the DSRIP will depend upon the ability to swiftly identify opportunity areas and develop targeted interventions.

In addition, access to a statewide data support structure will be necessary for the Commonwealth to accomplish its goals associated with data analytics, beneficiary information exchange, and a successful revised payment structure. Given that Virginia does not yet have a mature, fully

functional Health Information Exchange (HIE), establishing such an information portal could be quite a heavy lift. DMAS should anticipate investing significant DSRIP resources into this effort to ensure success.

3.3.1 Building Community Capacity/Training

VCUHS appreciates the recognition that the health care workforce of tomorrow must be better prepared to care for the entirety of the Medicaid population. Many of the current unmet needs can be addressed through creatively restructuring the delivery of care, disseminating effective models, and training the workforce in these models. If this training is a part of the formal programmatic education, increased integration of innovative delivery models into the curriculum of health professions schools needs to be fostered. Providing supporting for health professions schools faculty and staff working in the innovative models to host trainees needs to be considered. In addition, should this training become a part of continuing education for health care professionals, practitioners need to be incentivized to participate. This support needs to be directed at both the individuals working in the new models and the practitioners seeking re-training who have an economic incentive to stay in the old model.

Consideration should also be given to providing funding to support retrained or newly trained health professionals to disseminate the effective models to new settings. Effective dissemination will also require work between the practitioners, systems, DMAS, and state boards to ensure effective care, regardless of the health professional providing the service, can be reimbursed and support the practitioners.

In addition to ensuring that providers are properly trained in various skill sets, however, it will be critical for DMAS to dedicate DSRIP funds to bolstering the actual pipeline of health care workers. Given the many external pressures facing providers, the level of financial cross-subsidization that has long occurred to support clinical education and training is becoming increasingly tenuous. DMAS should focus on those efforts that will help to recruit and retain providers, including PCPs and behavioral health providers, particularly in geographic areas where there are care "deserts." It may be necessary to dedicate a portion of the DSRIP funding to appropriately incentivize such recruitment and retention efforts (examples could include, but are not limited to, loan payback programs, incentivizes for providers to practice in public/safety net settings, etc.).

3.3.4. – Housing and Employment Support

As explained in the above section related to "super utilizers," identifying and tracking social determinants of health will be a key pillar in supporting the success of the Virginia DSRIP program. However, VCUHS strongly believes that DMAS should consider going *beyond* "disseminating appropriate and available [safe housing/employment] options." A critical factor in the transformation of the delivery system will be the ability to effectively increase support services in housing settings for vulnerable populations. Indeed, adequate DSRIP dollars should

be designated to help offset the costs associated with delivering and implementing such social supports to this population.

3.4 – Transformation Step #4: Redesign How DMAS Pays for Services

VCUHS is hopeful that DMAS can clarify the following questions related to transitioning to alternative payment models (APMs)/value-based purchasing (VBP) models.

- DMAS indicates that it will include "initial value-based payment standards" in the upcoming RFP for MLTSS services. Presumably, the initial standards are being explored in the recently released RFI due to DMAS on October 21st. Does DMAS have a timeline for developing this APM/VBP framework? Will DMAS engage stakeholders throughout the process, beyond the initial RFI?
- Will the acceptance of (or agreement to) APMs/VBPs be a prerequisite for providers who wish to participate in VIP networks? If so, does DMAS anticipate that this requirement might discourage providers (particular those who are smaller, with fewer resources) from participating in the VIPs?

5 – Benefit and Cost Sharing Requirements

We have noted the last sentence in this section: "This demonstration does not include any cost-sharing requirements that are not currently authorized through the Virginia State Plan." Can DMAS provide rationale as to why increased beneficiary cost sharing is not being explored? Was this a parameter developed by CMS, or is there a chance this could still be negotiated?

While from a provider perspective we are sensitive to the challenges associated with collecting co-pays from a vulnerable population, from an integrated delivery system perspective, we do see the benefit to having the patient more meaningfully incentivized and engaged in the care plan. Perhaps there might be ways to financially award or incentivize the patient, which do not necessarily involve increased cost sharing obligations. VCUHS would encourage DMAS to explore any such opportunities.

7 – DSRIP Financing

VCUHS looks forward to additional, detailed conversations around DSRIP financing mechanisms. An initial question that has arisen is: does DMAS have any indication from CMS what proportion of funding must be derived through DSHPs, versus through IGTs? At first blush, it seems that many state expenditures could potentially qualify as DSHPs. Has CMS developed any parameters around the use of DSHPs, including whether or not the DSHPs must be relevant to the defined DSRIP population?

Concluding Remarks

VCUHS appreciates the dialogue that we have held with DMAS regarding the DSRIP project to date. We look forward to additional discussions and to working with you in the coming months on this initiative.

Sincerely,

Marsha D. Rappley, M.D.
CEO, VCU Health System
Vice President, VCU Health Sciences

Provider: Virginia Community Healthcare Association (VCHA)

TO: DSRIP@dmas.virginia.gov
Cc: Cindi Jones, Director, Department of Medical Assistance Services
Suzanne Gore, Director of Policy and Research, DMAS
R. Neal Graham, CEO, Virginia Community Healthcare Association

From: Rick Shinn, Director of Government Affairs
Virginia Community Healthcare Association

Date: October 19, 2015

RE: Comments on DSRIP and FQHCs

As the Commonwealth pursues DSRIP and a Section 1115 waiver, we would respectfully request that DMAS consult with the Virginia Community Healthcare Association on issues that may benefit DMAS and Medicaid recipients in Virginia, and that may impact Federally Qualified Health Centers (FQHCs), commonly referred to as community health centers in Virginia.

In particular, we believe that at some point, there may be a mutual benefit and need to discuss our partnership with DMAS in serving Medicaid recipients.

As Virginia looks to transforming delivery systems, we would suggest that reviewing the systems in place at FQHCs may show tremendous value to DMAS in areas such as:

- Electronic health records implementation
- Development of patient centered primary care medical homes
- Integration of behavioral, dental, pharmaceutical and medical care for FQHC patients
- Innovative prevention programs, such as diabetes management programs, and rural health outreach

Value of services can often be difficult to measure. As the Commonwealth looks to value based purchasing, one major concern will be the impact on the financial stability of safety net providers such as FQHCS. As a major provider of primary care services to Medicaid recipients in Virginia, changes to Medicaid via a Section 1115 waiver could have significant impact on FQHCs.

As you know, under federal law and regulation, FQHCS have a unique reimbursement that was set in place by Congress several years ago. This reimbursement system for FQHCs was designed to ensure that federal funds granted to FQHC organizations are focused on the intended purpose of establishing health centers in underserved areas, and serving the needs of all in the community, including those without insurance, Medicare, Medicaid, or other coverage or funds to pay for services.

We applaud DMAS in its efforts to pursue value based purchasing. At the same time, we would caution that unintended or intended actions that could impact FQHCS and their Medicaid reimbursement be discussed with us to ensure that the goals of all parties are achieved.

It is our firm belief, that FQHCS currently bring much more value to DMAS and Medicaid recipients than may be understood, or measured at present, and that this hidden value could be of greater benefit to DMAS than is currently understood.

Therefore, we strongly urge you to discuss with our organization and health centers, how FQHCs can assist DMAS in its goals, while ensuring the financial stability of FQHCS to serve not only Medicaid recipients, but all persons in their communities.

As a longtime partner with DMAS and the Medicaid program in Virginia, we strongly encourage you to work with our health centers to ensure that no harm comes to Medicaid reimbursements for FQHCs that could impact our financial stability, while maximizing value for DMAS and Medicaid recipients.

We look forward to continuing our work with DMAS to better serve Medicaid recipients across the Commonwealth.

Sincerely,

Rick Shinn
Director of Government Affairs
Virginia Community Healthcare Association

Provider: Virginia Health Care Association (VHCA)

October 19, 2015

Dear DMAS,

Thank you for the opportunity to provide input on the Delivery System Reform Incentive Payment (DSRIP) concept paper. As always, we appreciate the value DMAS continues to place on stakeholder input. The Virginia Health Care Association (VHCA) is a member-driven organization dedicated to advocating for and representing the interests of over 250 Virginia nursing and assisted living facilities and the 29,000 residents they serve through the selfless efforts of nearly 30,000 dedicated care-giving staff. We are proud of our role as the Commonwealth's largest association representing long term care. VHCA's strength, effectiveness, and integrity are significantly enhanced by the diversity of its membership which includes proprietary, non-profit, and government-operated facilities dedicated to providing the highest quality of care.

As we noted in our response to DMAS' separate comment solicitation for the Managed Long Term Services and Supports (MLTSS) Model of Care (submitted September 28th), we are in the process of working with DMAS staff to understand the linkage of the MLTSS program and DSRIP, as outlined in the recent concept paper. It remains unclear to our members how the two programs will interact in terms of the services our member nursing facilities provide, and the impact on the managed care delivery model envisioned under MLTSS. We continue to attend informational sessions / focus groups on DSRIP and DMAS staff have been open to discuss the two programs with us. As such, we are assured that additional opportunities for input will be forthcoming over the next several months as we gain more understanding of the programs.

Per the request for structured input, and again, based on our current and somewhat limited understanding of the detail as it pertains to nursing facility services, we respectfully provide the following comments:

Integrated Service Delivery

In the concept paper, this "transformation step" appears to be focused on community-based services as opposed to the institutional care which represents the primary service provided by nursing facilities within the confines of the Medicaid benefit structure. Our members also provide other services and supports outside of institutional care, but the Virginia Integration Partners (VIP) model appears targeted to community providers and support entities. We look forward to receiving more information on how nursing facilities and VIPs will interact with the managed care entities under MLTSS, and visa-versa, as the "integration" of care seems to be a goal of both entities, and a service which the managed care plans will already be providing. It is important to note that integration of care currently exists within the nursing facility for institutionalized individuals, as interdisciplinary care teams are required by federal

and state law and regulations to develop and deliver care plans to meet the needs, across all health services, for every resident. If meeting this goal will represent an added resource for nursing facilities, we would be very supportive of the concept.

3.1.1 Integrated Behavioral and Primary Care: VHCA remains very supportive of any additional resources available to assist in getting those with behavioral health issues the services they require. For our members, the integration of behavioral and medical care needs into a coordinated care plan and delivery site has not been the primary issue; the issue has been the limited availability of providers to meet those behavioral health needs.

3.1.2 Mobile Care Teams: As implied above, we applaud any effort to increase the availability and accessibility of behavioral health (and other) providers. We would recommend that the mobile care teams not just be a resource for individuals in the community, but also for on-site care delivery for institutionalized nursing facility residents. There may be some administrative hurdles to overcome (credentialing for the facility, etc.), but this outcome would be seen as a strong positive for our members.

3.1.3 Care Transitions/Diversions from Institutional Care: VHCA remains supportive of all efforts to delay or avoid the need of individuals for the institutional services our members provide under Medicaid. To the extent the DSRIP program can enhance community supports to further that avoidance, we are supportive. In terms of transitions, it is important to note that nursing facilities provide a cost-effective rehabilitation option for individuals discharging from an acute setting with significant rehabilitation needs. VHCA members have proven to be valued partners in recovery back to the home for patients with an acute episode. Because most of the transitions from nursing facilities involve Medicare-primary services delivered in the facility, it remains unclear to us how MLTSS (Medicaid-only) and DSRIP will influence this aspect of nursing facility care.

3.1.4 Super Utilizers: By definition, the extremely frail nature of those eligible for Medicaid long term care, particularly those in nursing facilities, means the medical needs of this population are significant. Unlike community-based long term care recipients, the facility population has greater access to on-site care-givers on a routine basis. It is not clear whether the nursing facility population would be the target of reforms around super-utilizers, but to the extent medical service availability is enhanced, we would certainly support the concept.

Data Platform

It should be noted that the PPACA excluded nursing facilities from the electronic health records (EHRs) incentive programs that provided significant capital to hospitals and physician offices for development of EHRs. As a result, we suspect there may be a “mixed-bag” in terms of EHR implementation and interoperability among the nursing facilities across the Commonwealth. To the extent DSRIP offered financial incentives to develop this infrastructure to facilities (as opposed to only VIPs, as outlined in

3.2.1 and subsequent sections) that lack such capital resources, this would be a positive component of the DSRIP proposal.

3.2.1 Data System Development: VHCA has no specific comments here beyond the general comment above; nursing facilities would benefit from available funding to make investments in EHRs

3.2.2 Link to Statewide Care Management System: Again, this goal is covered in the above comments

3.2.3 Minimum Data Standards: Nursing facilities collect the "Minimum Data Set" information that is utilized to both develop and deliver care plans and for reimbursement purposes. Additionally, there are numerous quality measures and other statistics already reported to various entities, such as CMS. We reiterate our comments made in the MLTSS Model of Care solicitation that DSRIP and MLTSS utilize existing measures that are already being reported. This would reduce the administrative burden for all parties.

Build System Capacity

VHCA's members are fully supportive of efforts to build system capacity through incentivizing increased community support, training and telehealth utilization. Increased community capacity will become even more vital as the baby boomers increasingly access long term care services and supports across the full spectrum of service delivery.

3.3.1 Training: VHCA members are fully supportive of efforts to address health care workforce shortages and to increase the availability of RNs, LPNs, and CNAs, and other health care professionals/providers, across the Commonwealth. As previously mentioned, we are also interested in increased provider capacity in the behavioral health field, as finding such professionals to take care of our residents is a challenge for nursing facilities. Any cross-training that can be achieved across service types, particularly behavioral health training within the various medical professional disciplines would also be viewed as positive by VHCA's members.

3.3.2 Crisis Management: Consistent with previous comments, we would postulate that crisis management may also be a benefit to those individuals residing in nursing facilities. While on-site care exists to take care of medical needs, and increased cross-training imbedded in the training referenced above would likely help, there may still be occasional needs for crisis stabilization for residents living in nursing facilities.

3.3.3 Telehealth: VHCA agrees that significant potential exists for greater utilization of telehealth to deliver care to residents of nursing facilities. To the extent DSRIP could assist financially with some of the infrastructure needs to allow for a robust and expanded use of telemedicine within nursing facilities (and in the community), this could be the catalyst for the Commonwealth to tap some of the unmet potential for efficiencies and access to providers, particularly in behavioral health, through telehealth.

3.3.4 Housing and Employment: In line with our members' desire to delay or avoid the need for the institutional care we deliver for those individuals for which available community supports can accommodate the clinical and social needs, we would support the use of DSRIP funding to increase the availability of housing and employment support. To the extent housing has been a barrier to community-based care in lieu of facility placement, increased options would be a positive development.

Payment Reform

This particular section of the concept paper is the primary section for which we need more detail to fully understand DMAS' intent. As you know, DMAS just implemented a major payment reform of nursing facility providers less than one year ago; this new methodology is still in transition and in many ways should still be considered a work in progress as both the providers and DMAS understand the implications of the new methodology going forward. With the advent of managed care within nursing facility services though CCC and soon-to-be MLTSS, the last couple of years and the next few years represent an era of significant change from the nursing facility service delivery and payment perspective.

Value-based purchasing can mean multiple things to multiple providers. For nursing facilities, it is difficult to contemplate what value-based purchasing might mean when limited to care delivered under the Medicaid-primary benefit of custodial long term care (MLTSS is Medicaid-only). This is particularly true given that Medicaid reimbursement has historically been capped below cost for a large number of facilities, with other payers (Medicare, private pay, etc.) allowing facilities to cross-subsidize the cost of the Medicaid recipient's care. Most care transitions in the nursing facility industry involve Medicare-primary services (from the nursing facility to the hospital due to an acute episode or from the hospital for rehabilitation in the nursing facility). Value-based or other risk sharing arrangements have made more sense with these types of transitions/services, but it is difficult to contemplate these types of measures under MLTSS, which only represents the Medicaid benefit.

We would have significant concerns to a value-based approach to Medicaid-primary custodial nursing facility care that contemplated withholding a portion of payment for use in recognizing adherence to certain quality metrics without adequately recognizing provider cost in the rate setting process on the front end; the current methodology does not adequately address cost across the board. To the extent the value-based approach included positive incentives (additional payment) associated with adherence to certain metrics, this would be ideal. Until further details are provided on the value-based approach for nursing facilities and the interaction in this regard with the MLTSS plans, we respectfully reserve judgement on this concept and state our willingness to work with DMAS on this topic. At this point, we do not have specific comments on the two subsections within this transformation step.

Again, on behalf of our membership, I would like to thank you for the opportunity to provide comments on the DSRIP concept paper. We have attempted to limit our comments to the four transformation steps as requested in the public comment request. In addition to those components of DSRIP, we remain interested in a conversation regarding the envisioned interaction between MLTSS and DSRIP as it pertains to nursing facility services, as well as more detail surrounding the state funding of the DSRIP request. We look forward to more details and continued conversation around these significant reforms.

Sincerely,

J. Keith Hare

President

Provider: Virginia Health Care Foundation (VHCF)

October 19, 2015

To the DSRIP Steering Group:

Thank you for taking the time and effort to so conscientiously research and create a DSRIP plan that will help Medicaid patients receive behavioral health services in an integrated manner within the community at lower cost. Your work and vision are very exciting! Please accept these comments on the DSRIP concept paper posted for public comment.

3.1.1 Integrate Service Delivery

The Virginia Health Care Foundation (VHCF) has been engaged in promoting and funding the integration of behavioral health services with primary medical care for the past six years. For the first four years, we funded and administered an initiative, "A New Lease on Life". This underwrote nine 3 year grants that required collaboration between Virginia's local public mental health agencies and their local health safety net provider (FQHC or free clinic). We convened all nine of the grantees quarterly to in a learning collaborative to share experiences and lessons learned. The experience convinced us of the tremendous value of integrating delivery of behavioral health and medical care, and taught us about a number of significant challenges to achieving true integration.

Some things to keep in mind are the difference in approach and cultures of medical professionals and behavioral health professionals; the importance of using electronic health records that all involved health professionals can access and use easily; the tendency to have high "no-show" rates for behavioral health appointments, especially the first ones; the importance of continuously nurturing integration via organizational leadership and protocols; and the tremendous shortage of behavioral health professionals in most parts of Virginia.

At this point VHCF has funded 20 initiatives that integrate behavioral health with primary medical care. We will be happy to work with you to provide insights from past and current behavioral health integration grants, as the need for help or questions arise.

3.3.1 Training

Nearly 3/4 of the Commonwealth of Virginia is a mental health professional shortage area. This makes it extremely difficult to find and retain behavioral health professionals. We experienced this firsthand through the A New Lease on Life initiative. It was not unusual for a behavioral health provider to leave a position, and go to another one that appeared to be more attractive. It is definitely a "sellers market" for behavioral health professionals in Virginia.

As a result of this experience, we explored how to address this very challenging workforce shortage. We discovered that all behavioral health professionals have a 4 - 6 year pipeline of post-graduate training and education before they can practice. The only exception is for Psychiatric Nurse Practitioners (Psych NPs). They only require two years of training, and have prescriptive authority after they pass their boards and receive their credentials. They are the only behavioral health providers other than psychiatrists who have the ability to prescribe and manage psychotropic medicines in Virginia.

Unfortunately, there are only 155 psych NPs in Virginia. That is barely more than one per locality! As you contemplate the best way to build community capacity, I encourage you to consider measures that would increase the number of Psych NPs trained by Virginia's schools of nursing so that the Commonwealth has more many more of these very valuable behavioral health professionals.

VHCF has taken a small step to increase the number of Psych NPs by providing full scholarships for existing nurse practitioners who work in Virginia's healthcare safety net and want to expand their scope of practice by returning to school for postgraduate education to become a Psych NP.

As we move more to behavioral health integration in Virginia, a nurse practitioner who has both medical and behavioral health training will be very valuable as a "translator" to both medical and behavioral health professionals in his/her practice.

In talking with the deans of some of Virginia's leading schools of nursing about the need for Psych NPs, they have indicated that they do not have sufficient faculty to expand or sufficient sites for clinical experiences and preceptorships. All of this can and should be developed so that we can increase the number of behavioral health providers in Virginia as expeditiously and cost effectively as possible.

3.3.3 Telehealth

Many studies have shown the value of using telehealth to address behavioral health issues, especially in rural areas that have few, if any, behavioral health providers. The Virginia Department of Medical Assistance Services has been very innovative in utilizing and paying for telehealth for a number of treatment, diagnoses, and conditions.

The extension of telehealth to additional services under DSRIP could be very beneficial for both the state and its Medicaid patients. As with anything in telehealth, it will be important to ensure that there are sufficient medical and behavioral health professionals available to provide their services at the other end of the telehealth connection. This has been a problem from time to time, especially in the area of behavioral health. This is all a reflection of the tremendous shortage of behavioral health professionals in Virginia.

I hope this information is helpful. Thank you again for devoting so much energy and effort to move Virginia forward.

Sincerely,

Deborah D. Oswalt

Provider: Virginia Hospital and Healthcare Association

October 19, 2015

Ms. Ashley Hazelton
Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia 23219

Re: Virginia Hospital & Healthcare Association Comments – DSRIP Concept Paper

Dear Ms. Hazelton:

The Virginia Hospital & Healthcare Association (VHHA) appreciates the opportunity to respond to the Department of Medical Assistance Services (DMAS) request for public comment on the Delivery System Reform Incentive Payment (DSRIP) program concept paper released mid-September.

Building on the Commonwealth's current managed care delivery system in order to strengthen services for the most vulnerable through expanded community services and an integrated, person-centered model is both absolutely necessary and complex. The fundamental opportunity of the DSRIP program is to undertake this much-needed work with additional resources and a common strategic vision.

VHHA's membership, as you have heard from those serving on our *DSRIP Advisory Workgroup* agree fully with the underlying concept of the DSRIP proposal and look forward to engaging on the work ahead. We are committed to continued close collaboration with DMAS staff and other stakeholders to craft a successful waiver proposal.

At this stage of the process, there are four broad comments we would like to offer with regard to the concept paper and the next steps on designing Virginia's DSRIP proposal.

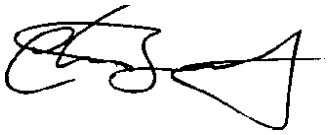
- **Accelerating availability of base-line data about target populations** – efforts such as these that involve working across multiple organizations to achieve results stand a much better chance of success if everyone has access to complete information about the target population.
- **Identifying clear goals for improvement –** these collaborations also require a clear understanding of the ultimate goals that everyone commits to pursuing. While each region and VIP will need to specify their own specific objective, there is value in setting some broad strategic goals for all to pursue. For example: achieving a significant reduction in avoidable ED visits; lowering avoidable hospital admissions or readmissions; and lowering institutionalization of recipients. The baseline data should inform these goals, but we have learned from successful health care quality improvement initiatives that clarity on the "what" (e.g., 20 percent reduction) by "when" (e.g., by 2020) is helpful.
- **Allowing choice of target population** – certain integration partners may select to focus on subsets of the potentially affected population groups (e.g., those with serious behavioral health and other chronic care needs vs. recipients currently receiving long term care services). Allowing multiple VIPs in a particular region to co-exist if serving distinct populations could yield more innovations to be implemented and evaluated.
- **Defining the key participants in and basic obligations of VIP participants –** without being too top-down in specifying the precise structure of each VIP, it would be very useful if the agency could

describe the basic obligations of VIP participants and offer guidance on key participants that should be involved. An example of the former would be that each participant be willing to commit to sharing time, energy and resources to implementing system changes (e.g., IT) necessary to fulfill their component of the delivery system innovation developed by the group. For the latter, in addition to ensuring that key health care providers and social sector agencies participate, we would encourage that health plans be invited to participate in each VIP – both to contribute to the group's work, but also to begin the process of designing the basic parameters of sustaining payment reforms for successful models.

Additional, more detailed questions and general comments about the DSRIP concept paper from one of our advisory group members (Donna Littlepage of Carilion Clinic) are enclosed.

Thank you for the opportunity to comment.

Sincerely,



Christopher S. Bailey
Executive Vice President

Enclosures: (1)

Comments on Department of Medical Assistance Concept Paper
Accelerating Deliver System Transformation in Virginia's Medicaid Program

3.1 The goal of encouraging/supporting participation of non-medical community services in the VIP groups will be very beneficial to the Medicaid recipients. It may be useful for DMAS to support conveners to bring each local VIP group together. Providing a listing of Medicaid participating providers in the market as well as other social services available would be beneficial.

3.2.2 A statewide managed care system could be very useful especially if it could link back to the EMR of each provider. Many large providers in Virginia utilize the EPIC EMR which could be an initial catalyst to getting started with this. It would be helpful if this system was not just limited to Medicaid patients since providers need a care management system for all their patients and it is inefficient to utilize multiple systems. Allowing its use for other patients may encourage acceptance by many provider partners in the VIP groups. Also this system would need to help record/address other issues Medicaid members have such as housing, nutrition, transportation, medication acquisition, health education, etc. It will be very good if the same system and structure were used statewide.

3.3.4 A common listing of appropriate housing and employers willing to hire SPMI individuals could be very helpful in managing this population.

3.1.1 It is understandable how behavioral health can be a natural extension of primary care; however, it is difficult to see how it would work the other direction. Would need more details on how accessing services at a behavioral health site would allow access to other primary care services.

3.1.3 The model of care described mentions the Coleman Model but we believe that combining it with elements from the Naylor Transitions of Care Model would be more effective.

3.1.4 The Model of Care will likely need to address the varying levels of Medicaid recipient. It discusses implementation support for hospital care coordination efforts and extended office hours. Unsure what funding structure is intended to support implementing these services and how it will be addressed at the end of the five year period.

3.3 The concept does not address education on making health decisions including choices on what care to receive and under what circumstances.

3.3.1 Training commentary does not specifically address how DMAS plans to increase the availability of behavioral health resources. This is an issue which cannot necessarily be addressed within five years.

3.1, 3.1.2 and 3.4 The concept paper fails to address the issue of additional funding for the infrastructure that will be needed past the five year mark of this project. DMAS desires to move to value based payments, but already pays less than cost and is asking providers to increase their investment further. For example, mobile clinics have not been shown to be financially viable overall and that would only be exacerbated at Medicaid payment rates. It appears reasonable to request further information in this area such that providers are willing to participate in the VIPs. Would Medicaid consider eliminating co-pay for urgent care to decrease use of the ED or cover the Transition of Care Management and Chronic Care Management reimbursement methodologies as Medicare has done. They want VIPs to develop a sustainability plan past five years. DMAS will have to increase funding to the providers and/or VIPs based on their savings. Otherwise, this whole idea may not be feasible if it will simply cost the providers even more.

IMPLEMENTATION COMMENTS

3.2 In developing the technology platform, DMAS should have significant provider input to ensure the achievement of their goals related to team-based care and measuring outcomes. The providers would rather not see DMAS' system become one more insurer system they would need to access separately.

Links to other models DMAS might like to review
Http://archive.ahrq.gov/news/newsletters/research-activities/jun11/0611RA1.html
Https://www.communitycarenc.org/

Provider: Virginia Pharmacists Association (VPhA)

October 19, 2015

Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219
dsrip@dmas.virginia.gov

RE: DMAS Delivery Service Reform Incentive Payment (DSRIP) program

The Virginia Pharmacists Association, representing pharmacists in all practice settings across the Commonwealth, is pleased to provide comments concerning the proposed design and implementation of the DMAS Delivery System Reform Incentive Payment (DSRIP) program. We look forward to providing additional thoughts and suggestions as the DSRIP program design moves forward.

Pharmacists have bolstered and contributed to cost-savings through the development of innovative and population focused initiatives. The Pennsylvania Project demonstrated the impact of pharmacists screening and brief intervention on population-level medication adherence rates and healthcare costs. It concluded that the pharmacists' intervention increased adherence rates to high blood pressure medication classes and oral diabetes medications. With the increase in adherence rates, the study observed reduced healthcare costs in two of the studied medication classes.[6] Furthermore, the Asheville Project concluded that patients with diabetes who received ongoing pharmacy care services maintained improvement in A1c over time, and the city of Asheville experienced a decline in mean total direct medical costs as a result.[7] The cost-savings provided by pharmacists through these example initiatives include elements that are critical to the DSRIP program's successful design, development, and implementation.

A 2011 U.S. Public Health Service report noted the importance of including pharmacists in the delivery of patient care services. The report noted that "pharmacists improve outcomes, increase access to services for medically underserved and vulnerable populations, improve patient safety, shift time for physicians to focus on diagnosis and more critically ill patients, improve patient and provider satisfaction, enhance cost-effectiveness, and demonstrably improve the overall quality of health care through evidence-based practice."[8]

We would like to take this opportunity to provide comments on a few of the questions posted for public comment.

Delivery of Pharmacists' Clinical Patient Care Services

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[6] Pringle, JL, Boyer, A, Conklin, MH et al. The Pennsylvania Project: Pharmacist Intervention Improved Medication Adherence and Reduced Health Care Costs. *Health Affairs*, 33, no.8 (2014): 1444-1452.

[7] Cranor CW, Bunting BA, Christensen DB. The Asheville Project: long-term clinical and economic outcomes of a community pharmacy diabetes care program. J Am Pharm Assoc (Wash). 2003;43(2):173-84.

[8] Giberson S, Yoder S, Lee MP. *Improving Patient and Health System Outcomes through Advanced Pharmacy Practice. A Report to the U.S. Surgeon General.* Office of the Chief Pharmacist. U.S. Public Health Service. Dec 2011.

Pharmacists are vital members of the healthcare team and capable of providing accessible services to communities across the Commonwealth. Through our education, training, and accessibility, pharmacists are uniquely positioned to deliver quality patient care services. We strongly encourage the inclusion of pharmacists' quality patient care services through the DSRIP program. These services are broadly described as patient-centered, cost-saving, coordinated, accessible, comprehensive, and quality. More specifically, these services include, but are not limited to the following:

- Medication adherence, reconciliation, and management including drug-drug and drug-disease interaction prevention, duplication of therapy avoidance, drug regimen optimization, and therapeutic adjustment
- Patient education and counseling
- Chronic disease state management
- Transitional care management
- Immunizations and preventative health

Defined Governance Including Pharmacists
Flexibility within the governance structure has downstream benefits to the program. However, more defined governance structures ensure the appropriate and comprehensive representation of those stakeholders invested in the health and wellbeing of the Commonwealth. We encourage the development of more defined governance structures that include pharmacists and other healthcare providers.

Collaboration with the Virginia Pharmacists Association
The Virginia Pharmacists Association is the profession's voice throughout Virginia. In addition to the fundamental advocacy efforts on behalf of all pharmacists in the Commonwealth, the Association provides its members with educational services, local activities and programs, and communications among other services. This network and established structure will be necessary to the implementation the DSRIP program. Therefore, we encourage and welcome the continuation of the collaborative relationship VPhA has had with DMAS.

Again, we appreciate the opportunity to provide preliminary comments as the Commonwealth considers implementation of the DSRIP program for the Medicaid population that many of our pharmacists serve. We look forward to participating further in the development of a program that we hope will provide access to pharmacist-provided care and services to Medicaid recipients across Virginia.

Sincerely,

Timothy S. Musselman, Pharm.D.
Executive Director

Health Plan Comments

Health Plan: Anthem HealthKeepers Plus

October 19, 2015

Ashley Hazelton
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219

Via Electronic Mail to: DSRIP@dmas.virginia.gov

Re: Delivery System Reform Incentive Payment (DSRIP) Concept Paper

HealthKeepers, Inc. (Anthem HealthKeepers Plus) is pleased to submit our response to the Opportunity for Public Comment issued on September 11, 2015, regarding "Accelerating Delivery System Transformation in Virginia's Medicaid Program." As a wholly-owned subsidiary of Anthem, Inc., Anthem HealthKeepers Plus is part of an organization that is the nation's leading provider of healthcare solutions for government-sponsored programs.

Together with our affiliate health plans, we serve more than 5.6 million people in government-sponsored health plans in Virginia and across 18 other states, providing Managed Long-Term Services and Supports (MLTSS) in eight of these markets. In Virginia, we serve approximately 276,000 Medicaid and FAMIS beneficiaries as well as approximately 11,000 Medicare-Medicaid beneficiaries participating in the Commonwealth Coordinated Care program. We bring deep organizational expertise and passion for serving individuals with complex needs through a variety of government-sponsored programs.

As a long-time partner of the Virginia Department of Medical Assistance Services (DMAS), we look forward to continuing our collaborative role and fully supporting Virginia's goal of transforming the Medicaid program from Fee-For-Service (FFS) to a value-based delivery system where quality, efficiency, and cost effectiveness is rewarded.

Should you have any questions regarding this submission, please contact me by phone at 804.354.7060 or via email at patrick.sturdivant@anthem.com.

Sincerely,

Patrick Sturdivant
President, Virginia Medicaid

Anthem Response to DMAS Questions for Public Comment

3.1 Transformation Step #1: Integrated Service Delivery

In our experience, the collaborative approach necessary to serve this population requires local partnerships with our members, their providers and their families to develop individual care plans designed to help improve the member's general well-being and provide access to independence, full participation and community living in the most integrated environment of their choice. Therefore, we understand the Department's desire to create an opportunity where providers will come together and create community-based networks known as Virginia Integration Partners (VIPs), but we would urge DMAS to ensure that Managed Care Organizations (MCOs) are the leaders in the development of these new networks from the outset of the DSRIP program. As seen in the Medallion 3.0 program, MCOs already have mature provider networks, partnerships with providers and Value-Based Payment (VBP) programs in place that can be leveraged to help accomplish the transformation goals as outlined by the Department. Additionally, MCOs can provide individual administrative support, process timely provider payment to support cash flow, as well as provide robust data and infrastructure to support the transformation to increased VBP.

Recommendation(s):

Build the chassis of the DSRIP program on existing MCO framework. Anthem recognizes DMAS's vision for bringing together community-based VIPs similar to Accountable Care Organizations (ACOs). However, we encourage DMAS to consider that MCOs are in the best position to help DMAS successfully meet its VBP goals given that they already have the infrastructure in place and are performing the same delegated functions, including the care coordination/management services envisioned for the VIPs. Additionally, MCOs bear risk for these services and we strongly believe that care management must be aligned with financial risk to achieve the best possible outcomes. Having MCOs drive the process and giving them the capacity to work with a range of providers, including VIPs, to implement value-based programs and initiatives represents the most realistic option to meet the Commonwealth's short- and long-term goals.

Budget predictability and faster transition of risk. An MCO model provides immediate budget predictability and transition of risk, as well as an enhanced ability to manage costs and improve future cost trends for Virginia. One of the most important lessons learned through the early experience of provider-led arrangements – such as ACOs – is that practices often overestimate their ability to manage risk.[9] Under a standalone ACO-like model such as the proposed VIPs, most states have elected to shift risk over time to ensure that providers are not put at risk before they have the financial and operational capabilities to assume that risk. The early experience of private integrated MCO-ACOs also found that some providers were not ready for risk initially, but were willing to work with their MCO partners to gradually assume more risk.[10]

[9]. Agency for Healthcare Research and Quality. *The State of Accountable Care Organizations* – based on an interview with Stephen Shortell, Ph.D., MPH, MBA.

[10]. Aparna Higgins, Kirstin Steward, Kirstin Dawson and Carmella Bocchino. Early Lessons from Accountable Care Models in the Private Sector: Partnerships Between Health Plans and Providers. *Health Affairs,* 30, no.9 (2011): 1718-1727.

3.2 Transformation Step #2: Build a Data Platform for Integration and Usability

Managing care for the vulnerable and often medically complex Medicaid population in a cost-effective manner is challenging for providers and requires unique knowledge, experience and infrastructure. While MCOs have a long history of successfully managing the health of delicate populations, providers may struggle with making required investments and performing core functions such as administrative, financial, organizational, data and information sharing, Health Information Technology, community partnerships, quality and cost evaluation and reporting. Ensuring a strong MCO presence and participation in its delivery system reform assures Virginia that it will continue to benefit from the strong managed care presence and experience that already exists in the Commonwealth.

Recommendations(s):

In our experience, the following elements are critical for successful implementation of a VBP model:

- We suggest that DMAS invest dollars in helping increase technology capabilities across providers in Virginia, such as offering grants (using DRSIP funding) that encourage widespread adoption of electronic document sharing to enhance care coordination. MCOs have the capabilities and resources to support these efforts and to work with providers immediately to develop the necessary data and interfaces in a way that providers can use.
- Technology adoption and use can vary widely across providers; thus, MCOs must be able to deliver information in a way that providers can use while also promoting the benefits that health information technology can offer, including better care coordination, prevention, wellness, and improved quality.
- MCOs must have sophisticated data analytics to identify opportunities to enhance outcomes and implement strategies that result in improved health and wellness. In order to sustain a model focused on wellness and prevention, MCOs should have capability for data sharing with other system partners to help facilitate a more holistic view of participants to coordinate their care.
- Anthem supports DMAS' intent to utilize DSRIP funding to support implementation of protocols that address high utilization of Emergency Department (ED) and inpatient hospital care. Our own experience in this area has underscored for us the importance of providers having access to the information necessary to allow them to coordinate care for these "super-utilizers." Emergency Department Information Exchange (EDIE) is a technology that has been successfully deployed and utilized in other states to support their Medicaid ED utilization program. EDIE collects data from all EDs visited by a patient, packages that data into actionable insights, and then delivers those insights to ED clinicians via real-time notifications the instant they are needed. HIEs are about moving data from point A to point B. In contrast, EDIE is not concerned with simply passing clinical information back and forth across hospitals, but about controlling ED utilization by providing a technical framework which governs a set of ED-specific care coordination workflows across disparate ED providers and case managers. By coordinating the efforts of these providers, facilitating the collection and communication of relevant, minimum-necessary insights and care plans across these individuals, and then communicating directly within these providers' existing workflows, EDIE is able to singularly tackle complex patient ED utilization by enabling all relevant stakeholders to act in concert with one another.

3.3 Transition Step #3: Build Community Capacity

Anthem understands that the transformed delivery system must address the medical, LTSS, behavior and substance use needs of Medicaid beneficiaries in order to be successful. MCOs have experience in building integrated provider networks with adequate capacity, breadth and scope to provide and coordinate the full spectrum of physical, behavioral, social and functional care and services for Medicaid

beneficiaries. Our ability to engage, educate and collaborate with providers and support their business needs can in turn support the Commonwealth's goal to build community capacity. The strategies identified by DMAS to build community capacity include training, statewide crisis management, telehealth and housing/employment. We welcome the opportunity to work with the Department in deploying its strategies for developing community and provider capacity within our networks that will address the needs of Medicaid beneficiaries.

3.4 Transformation Step #4: Redesign How DMAS Pays for Services

Anthem supports DMAS' efforts to utilize DSRIP funding to expedite the transition to value-based reimbursement methodologies for Medicaid. We recognize that developing a new payment model that rewards high-quality, interdisciplinary care; seamless transitions of care; and the integration of social supports is a monumental undertaking. We support DMAS' plans to invest DSRIP funding help Medicaid providers expand their capabilities to perform successfully in value-based reimbursement. Anthem encourages DMAS to work with the contracted Medallion 3.0 health plans to further this effort. Our experience and infrastructure provide providers with a platform to improve care coordination and health outcomes through innovative value-based reimbursements and MCO supports.

Recommendations:

Leverage the current Medallion 3.0 MCO infrastructure. Anthem recommends that DMAS leverage the current Medallion 3.0 MCO infrastructure and focus its initial efforts on expanding value-based reimbursement in the Medallion 3.0 program first, rather than the MLTSS program. Providers will need time to adjust to managing LTSS in Virginia, so adding VBP programs – programs not prevalent in LTSS today – will add an additional layer of complexity. Therefore, we recommend that VBP models align with the Virginia provider community and that MCOs have flexibility in tailoring these models to meet the needs of each provider – from large volume, integrated delivery systems to PCP-based organizations and from behavioral health to LTSS providers serving members with specialized support needs. We believe MCOs are in the position to create unique partnerships with each provider. By using CMS value-based reimbursement categories and establishing appropriate goals aligned with the specific Medicaid and MLTSS populations, while not being prescriptive on the exact form of VBP arrangements MCOs must implement, Virginia's health care delivery system can reap greater overall benefits.

To be truly effective, VBP programs must set attainable goals and must take provider capabilities into account. While not universally true, the majority of behavioral health and LTSS providers are not familiar with or structured to participate easily in typical VBP programs. Additionally, baseline data would not be readily available for MLTSS provider services, requiring a longer timeframe before effectiveness could be determined and outcomes goals realized. Many LTSS providers have limited or no experience in value-based reimbursement. Transitioning to VBP requires significant investment in provider education to help LTSS providers to prepare to be effective in value-based reimbursement programs. Performance and quality indicators relevant to LTSS providers and data needed to measure LTSS provider performance are not as prevalent. Attribution of members is more challenging with LTSS providers than it is with primary care providers.

Leverage MCO experience implementing VBP models. Anthem believes that it can bring valuable experience to DMAS by partnering to expand a Virginia-specific value-based care program that maintains patient-centered health care system but allows health plans like Anthem to create innovative programs to engage providers, including the newly formed VIPs, and promote quality care. Understanding a fully-mature shared savings program typically requires two to three years to incorporate baseline quality data

and then measure performance against targets, the Commonwealth would benefit from leveraging Medallion 3.0 MCOs with established data sources and reliable baseline data from our positive experiences administering these models in acute care programs.

Allow for flexibility in development of VBP models. To support the development of effective VBP models, we also believe it will be important for DMAS and MCOs to work collaboratively in establishing the broader program design, including overall benchmarks, categories, and goals. Given the various VBP models, clear expectations are essential as is standardization in definitions of reimbursement categories to assure consistency in measurement across programs and populations.

Once these overall parameters have been established, we recommend that MCOs be given the flexibility to innovate and create their own unique VBP approach around these parameters. MCOs have the experience and expertise to develop innovative incentives tailored specifically to the State's goals and needs of the populations served.

Further, DMAS should consider alignment with CMS's value-based reimbursement category definitions, but allow MCO's flexibility on determining specific incentive models within those categories. We recommend that DMAS consider establishing performance targets based on the percentage of members impacted by provider value based purchasing arrangements, rather than on total spend. We based this recommendation on the unique Medicaid delivery system factors, including:

- Overall spending on Medicaid is characterized by a disproportionate percentage of provider payments directed to providers who primarily serve members with specialized health needs. These providers generally serve a smaller number of members given their more complex and intensive health care needs.
- Medicaid serves all regions statewide, including rural areas, which means enrollment may be spread out across a large number of providers
- Some providers may place limits on the amount of Medicaid members they serve, which contributes to broader distribution of members across providers with smaller panel sizes

To counter these factors, MCOs develop innovative incentives tailored specifically to the goals for the Medicaid population that are more tactical and measured in an actuarially sound manner (incentives for transitioning members from a facility to a home environment, incentives for closing HEDIS care gaps, availability of after-hours appointments). These types of programs can be highly effective in producing improved health outcomes. However, while payments to these providers would be countable as value based reimbursement, they account for only a fraction of the total medical spend, and thus would not make significant progress towards a substantial total medical spend threshold.

Additionally, all forms of provider value based purchasing (FFS with a tie to quality, alternative payment models based on a FFS architecture, and population based payments) should be counted in measuring progress towards the targets. This way, a member who receives care from a PCP in a value based purchasing program designed to increase preventive services and access to primary care is counted fully, even if hospital or specialist costs are not "counted" for the program evaluation purposes. This will also allow MCOs the flexibility to develop new and innovative programs that are designed to meet the State's quality and outcome goals.

Anthem suggests establishing a relationship between quality measure achievement and auto assignment of members. Anthem proposes the State establish a quality measure whereby those MCOs who meet a specific threshold across a defined set of measures be eligible to obtain additional auto assignment of members. Maximizing enrollment with MCOs who earn high performance marks in VBP arrangements will not only incent the MCOs, but also further the Commonwealth's goals of serving more members through effective VBP programs. Further, we believe auto-assignment offers a valuable alternative to financial incentives that will enable MCOs to drive consistency in quality and programs regardless of the State's budgetary considerations as well as take the complexity out of linking quality incentives to annual premium adjustments.

Health Plan: CareSource

INTRODUCTION

As the largest Medicaid Managed Care Organization (MCO) in Ohio, CareSource applauds DMAS efforts to improve Medicaid service benefits and delivery systems for its Medicaid members. With a strong history of serving Medicaid members in Ohio and in Kentucky, we are a leader in behavioral and physical health integration and in our provider and community relationships, believing that both elements are critical to helping our members achieve better overall health. We appreciate the opportunity to comment and share the insights gained through our Medicaid experience.

3.1 TRANSFORMATION STEP #1: INTEGRATE SERVICE

CareSource Recommendations:

- Robust data sharing system
- Population health management that is both high tech and high touch
- Behavioral and physical health integration through Health Homes
- Inclusion of community partners in the member care continuum and by encouraging timely care in the most appropriate setting

Robust Data Sharing. CareSource recommends a robust data sharing system between plans and providers, allowing visibility into member data to coordinate care appropriately. Data contained in online provider portals and updated in real time help facilitate improved care coordination by identifying members who need preventive care or need intervention. Portals should also contain member utilization and medication history, including gaps in care for physicians and behavioral health providers to use during member visits. Information should be used to assist in developing a member care plan and as a reminder for needed preventive health services.

Population Health Management. Person-centered coordinated care is realized through population health management, eliminating the one size fits all approach to care coordination. Population health management allows for service design/delivery that is tailored to the members being served, addressing barriers, impacting member behavior, adherence, and progression through the health continuum, as well as guiding the allocation of resources based on the needs of a population. A high-touch, population health management approach to care goes beyond telephonic outreach to personal, face-to-face interaction that is more effective at improving health outcomes.

An integral part of population health management is a focus on wellness and prevention. CareSource is partnering with a health engagement and behavior change technology company that is helping us optimize our health and wellness programs through multi-model, adaptive digital coaching experiences. The coaching experience can be accessed through our online Member Portal and focuses on education and self management tools.

Integration of Physical and Behavioral Health. CareSource recommends the use of Health Homes to successfully integrate physical and behavioral health. In Ohio Medicaid, an integrated Health Home is typically provided by a community mental health center (CMHC), or community service board. Very few medical homes in Virginia incorporate community service boards, ignoring a much needed focus on the unique needs of members with behavioral health and/or substance use issues. Health outcomes can be affected through integrated care of medical and behavioral health and through provider incentives. This model will also allow for increased outpatient costs and decreased pharmacy and inpatient costs, offsetting the costs of outpatient visits.

Inclusion of Community Partners. CareSource recommends the inclusion of community partners in the member care continuum. Their role can be critical in encouraging timely care in the most appropriate setting, while allowing Plans, through these partners, to maximize care coordination and leverage appropriate community resources. Pertinent community partners include, but are not limited to, community-based agencies that offer the full continuum of direct care management services, Health Homes, social service agencies, etc. Local community-based organization are ingrained in the culture of the community and its Medicaid members and have access to other supports and providers to help provide the full continuum of care.

3.3 TRANSFORMATION STEP #3: BUILD COMMUNITY CAPACITY

CareSource Recommendations:

- Investment in a robust network of behavioral health providers that can meet member needs and improve health outcomes
- Maintaining community tenure for members who can safely and effectively be served in less restrictive settings
- Active assessments, frequent face-to-face care team interaction, and proactive care management intervention for high risk members
- Determination of member acuity and subsequent care management interventions that are comprehensive and dynamic, possessing the ability to be reassessed and modified on a frequent, real time basis in response to the changing conditions and needs of each member

In building community capacity, Plans can have a positive impact on workforce expansion through effective trainings and interactions with community resources. In training a workforce of providers and community agencies that can address a variety of needs, Medicaid members in crisis will greatly benefit as access to resources will open up and over-reliance on institutionalization can be decreased.

Robust Network. Of the gaps in community workforce, behavioral health access is one of the largest. CareSource recommends that Plans improve access to behavioral health providers and making the impact on the workforce that is needed to improve quality of care and member health outcomes. Investment in a robust network of behavioral health providers that can meet the needs of its members and improve health outcomes gaps in behavioral health access include can effectively influence:

- Workforce. By increasing the number of those in the workforce, access can be significantly increased.
- Skill. Inclusion of primary care professionals and pediatricians in workforce development. Historically, neither specialty is comfortable addressing behavioral health issues, resulting in these important needs going unmet.
- Workflow/integration. A system that does not have the capacity to integrate physical and behavioral health needs leads to unnecessary escalation (heavy handed solutions), such as unnecessary hospitalizations. Integration can result in proper utilization, increased health outcomes, and decreased costs.
- Policy. Integration of a specialty behavioral health system eliminates gaps in access (e.g., significant administrative rules/burden, separate operational workflows, and physical/literal removal from traditional healthcare environments) and allows for accountability for quality/access.

Community Tenure. Nationally, comprehensive efforts must be made to balance where state Medicaid resources are spent, i.e., home and community based services (HCBS) vs. institutional settings for the provision of long-term services and supports (LTSS). Many state systems have insufficient options for members who wish to return home following an institutional stay and long-term care facility providers are often not challenged to proactively assess each institutionalized member's feasibility of returning to less restrictive settings of care. Maintaining tenure in the community must be emphasized for vulnerable members whose needs are complex but who can safely and effectively be served in less restrictive HCBS settings with proactive, person-centered care and LTSS service planning. Transitional and nursing facility diversion programs emphasize the proactive assessment and provision of transitional case management and other "wrap around" services to institutionalized members.

Assessments. To maintain maximum tenure in the community, prevent avoidable hospitalization and institutionalization, and assure optimal health outcomes, vulnerable members with complex care needs and/or those in crisis need the benefit of highly engaged, well-informed, and actively communicating transdisciplinary care team approach. Effective community based HCBS LTSS case management is necessary, and active face-to-face assessment, frequent care team interaction, and proactive care management intervention for high-risk members must be considered a mandatory feature of any successful managed LTSS (MLTSS) program. Community service options will include direct care services such as nursing and personal care, but also take into consideration a broad array of ancillary services, supports and resources that high-risk members may require to remain safely in the community, such as non-medical transportation, respite care, home/vehicle modifications, chore services, emergency response systems, etc.

Care Management Interventions. Plans must have the capability to stratify members based on a variety of factors, not all of which are medically or diagnosis driven. Functional limitations, for example, have a strong and direct correlation to member outcomes and those with chronic conditions and functional impairment have an increased risk of unplanned re hospitalization as compared to those with chronic

conditions alone. Member acuity and subsequent care management interventions must be comprehensive and dynamic, possessing the ability to be reassessed and modified on a frequent, real-time basis in response to the changing conditions and needs of each beneficiary. Provider networks serving MLTSS beneficiaries should be required to adhere to well-defined criteria of minimum competency and quality assurance/training certification standards. To support a culture of person-centeredness, self-directed care and treatment options should also be provided for those beneficiaries who may demonstrate the desire and ability to take a more active role in the management of their care and services.

3.4 Transformation Step #4: Redesign how DMAS Pays for Services

CareSource Recommendations:

- Robust and timely data around member utilization, allowing for at least monthly reporting of member utilization of incentivized services to aid in cost control
- Incentives tied to quality targets
- Appropriate assignment of member primary care provider, allowing for providers to be incented for the members for which they are actually caring
- Adequate support for providers, including timely reporting, outcomes monitoring, clinical outreach support, and collateral training materials
- Two-way data exchange
- Incentives for increased access to preferred providers
- Incentives for providers to perform risk assessments, care coordination, clinical documentation, disease management, and high risk case management

CareSource applauds the state's efforts to establish readiness with Virginia Integration Providers, other DMAS providers, and health plans to implement value-based payments. CareSource has committed to continuously evaluating and improving its value-based reimbursement (VBR) strategy so that the focus on quality outcomes is paramount, and to partnering with providers who demonstrate the same commitment to quality health care. Since our initial programs, we have implemented a total cost of care shared savings program and a pilot incentive program in place with CMHCs for a behavioral health initiative.

Our recommendations for a robust VBR model that addresses each of Virginia's challenges includes:

- Robust and timely data around member utilization, allowing for at least monthly reporting of member utilization of incentivized services to aid in cost control
- Incentives tied to quality targets
- Appropriate assignment of member PCP, allowing for providers to be incented for the members they are actually caring for
- Adequate support for providers, including timely reporting, outcomes monitoring, clinical outreach support, and collateral training materials
- Two-way data exchange (HIE)
- Incent increased access to preferred providers

- Incent providers to perform Risk Assessments, care coordination, clinical documentation, disease management, high risk case management

After administrating programs and gathering data related to the contracted programs, CareSource has identified areas where enhancements can be made to improve success for both member outcomes and provider incentives. These include:

- Member/Provider Alignment. Ensuring that providers are incented based on members they see.
- Provider/Quality Measure Alignment. Incenting quality measures that are aligned with the provider affecting the care.
- Demonstration of Commitment to Quality Outcomes. Providers should be contracted for programs after having demonstrated commitment to quality outcomes.
- Adequate Support for the Providers. Adequate support includes timely reporting, outcomes monitoring, clinical outreach support, and development of collateral training materials.

Benefits are felt across the board when provider incentives are properly aligned to quality targets and when providers receive full health plan support. Successful implementation of provider incentives can also lead to improved member health outcomes and decreased costs to the state.

Health Plans: Molina Healthcare

Delivery System Reform Incentive Payment (DSRIP)

Transformation: Molina Healthcare Feedback

3.1 Integrate Service Delivery (Transformation Step #1)

Eliminate siloed care between medical, behavioral, and community supports.
Community Care Partners Molina Healthcare supports integrated care delivery to optimize health outcomes for Medicaid Beneficiaries. Managed Long-Term Services and Support (MLTSS) markets are among the most siloed in all of managed care. Complex benefits and funding structures, chronic care management difficulties, and a lack of centralized accountability organizations add layers of difficulty to integration. Virginia Integration Partners facilitates coordination among healthcare organizations. The team-based, interdisciplinary, and holistic model of care, combined with community-based transitional services, is consistent with our mission to serve beneficiaries across the continuum of care. In integrating services, organizations should know the strengths of the existing community-based support for members with complex and chronic conditions and be able to identify and address any gaps in service. Community organizations and home-based providers should be included as a central part of the integrated delivery system, as they are often first to recognize changes in member health status. Molina recognizes the value of engaging, supplementing, and empowering community organizations and commends DMAS for recognizing these entities as part of the VIPs.

3.1.1 Team-based, Integrated Behavioral Health and Primary Care
Molina's approach reduces barriers and silos and integrates a full range of medical, behavioral, and social services for comprehensive care tailored to member needs and preferences. Assessment, care planning, and interdisciplinary communication and collaboration are integral to this high-impact model, as they promote effective and efficient care coordination and the management of both cost and quality of care. Our care management strategy targets transition drivers to manage symptoms, maximize health outcomes, and minimize unnecessary utilizations.

To address the needs of the population, we screen members for unmet needs in physical, social, behavioral health, and functional areas that may require a variety of interventions and long-term services and supports (LTSS). In identifying the needs of the most vulnerable members, Molina accesses the member, caregiver, provider, or Home and Community Based Services (HCBS) referral; the provider referral; clinical data; and other resources. Assessment findings and clinical data are evaluated to assess the urgency of a member's needs and to assign the appropriate level of case management. We can simplify service delivery through integrated solutions.

3.1.2 Mobile Care Teams
Molina believes in meeting members where they are, physically and emotionally, and agrees with the concept of mobile care teams. We recognize the State of Virginia's accomplishments in leveraging Telehealth and suggests that it be considered, along with Mobile Care Teams, as part of an overall provider access strategy.

3.1.3 Care Transitions and Diversions from Institutional Care
Molina embraces the Coleman model and has developed a transition of care program using many of the Coleman model principles. We support Virginia's move toward this approach and advocate physical, behavioral health, and social integration and a more vertically-integrated provider network approach.

3.1.4 Addressing Super-Utilizers
Molina supports protocol implementations that improve and increase access to patient navigation tools, hospital care coordination, and extended primary care hours.

3.2 Build a Data Platform for Integration and Usability (Transformation Step #2)

Build the integrated clinical, behavioral, social and support data platform to accelerate provider integration and enable value-based payment.

3.2.1 Data System Development within VIPs
A data platform for supporting DSRIP transformation will require measurement and quality controls within value-based purchasing guidelines. Molina understands that information systems for integration must identify benchmarks, measure results, share data, demonstrate and build value, and support information gathering for process improvements. When implemented correctly, this system will serve to monitor and evaluate performance and identify opportunities for cost, communications, and services enhancements. Once the data platform is established, stakeholders can use the information to excel in the delivery of care and demonstrate measured progress. Our focus on data integrity will help ensure a strong foundation of good versus bad data for integration.

3.2.2 Providers Link to a Statewide Care Management System
Molina supports a statewide care management system that provides holistic, patient-centered care. Capabilities for statewide health information exchange between providers and community partners should be considered during planning, funding, and implementation of the statewide care management system. This may be an opportunity to collaborate with CMS in exchanging data not only for supporting effective care management, but also for redesigning pay services. (per concept paper 3.4 Redesign How DMAS Pays for Services.)

3.2.3 Statewide Set of Minimum Data Standards
A defined minimum data set (MDS) is important to meaningful provider data analysis. Standardized data and rules for key fields can be leveraged for value-based payments. For example, meaningful rules for populating data fields for settings of care (e.g. nursing home, hospital, community) and transition dates to or from a setting are important considerations if value based payments will be tied to community transitions or reduction in hospitalizations while institutionalized.

3.3 Build Community Capacity (Transformation Step #3)

Keep individuals safe and facilitate a life of meaning in the community.
Developing and sustaining community-based care for beneficiaries is fundamental for optimal outcomes. Molina supports community care models through education and training, from family caregivers to school nurses to clinical practitioners across regions. As an extension of person-centered care, we also support Telehealth implementation and expansion for accessing the appropriate experts for the level of care needed even in remote locales. To round out this community support, we invest in strategies and solutions

for crisis management and for facilitating housing and employment placement for improved quality of life that exceeds healthcare needs.

3.3.2 Statewide Crisis Management
Molina strongly supports DMAS' strategies to strengthen the statewide crisis management system.

3.3.3 Telehealth
Molina recognizes the State of Virginia's Telehealth accomplishments. Telehealth can be utilized not only for direct care, but also to engage specialists who may be in limited supply for meeting the needs of populations served by the state. An expert clinician engaged telephonically or through video conferencing with a local home-based clinician can contribute to member care in a cost-effective way.

3.3.4 Housing and Employment Support
Molina strongly supports innovative approaches to ending homelessness and promoting supportive employment. We encourage forums where members of the Medicaid delivery system engage with housing experts, including businesses, community members, and local authorities, who may partner to provide low-income, population-focused solutions.

3.4 Redesign How DMAS Pays for Services (Transformation Step #4)

Establish readiness within Medicaid Providers and Plans to implement and accept value-based payments.

Aligning providers with value-based methodologies is necessary for economic viability. Molina has experience employing value-based purchasing strategies. Our approach is a continuum that begins with pay-for-performance and quality, includes patient-centered medical homes and accountable care entities, and concludes with progressive risk and value arrangements. This approach tailors programs to the experience and sophistication of the provider community. All stages of the model have one common element: they are member-centric and outcome-based to ensure right care, right setting, and right time.

For example, in an early-stage pay-for-performance model, we reward providers when they demonstrate care competencies in providing quality care and improving access and health outcomes. Such outcomes include better access to primary and preventive care, lower preventable in-patient admissions and emergency room visits, and improved after-hours access on weekdays and weekends.

In the accountable care entity and progressive risk arrangement models, We are working with providers who have deeper experience with value-based payment models. Molina and the provider will share savings and risk for improving member care, member satisfaction, and outcomes.

Molina Healthcare is very pleased to support all four transformational steps in Virginia's DSRIP initiative. We would definitely like to participate in DSRIP and provided below is a contact for further discussions regarding projected implementation needs and appropriate timelines to achieve readiness and successful engagement in the DSRIP demonstration.

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Questions:
1) What level of investment and over what timeframe does the Department of Medical Assistance Services (DMAS) expect for funding the DSRIP initiative?
2) On what allocation basis and to what initiatives will DMAS distribute the DSRIP dollars?
3) What quality, cost, and satisfaction outcomes will be targeted for DSRIP?
4) What process will be used for a stakeholder to request DSRIP dollars?
5) Are all stakeholders eligible to receive DSRIP dollars?